

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12839

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

12861

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the same, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PN3. Page 5 may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY <u>Pr. Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u> 41	
c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		d. STREET ADDRESS <u>Box. 212 A Gorman Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Laurel Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <u>EDWARD</u>	Middle <u>KIRBY</u>	Last <u>ALLEN</u>
4. DATE OF DEATH	Month <u>November</u>	Day <u>10</u>	Year <u>1959</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4 Oct. 1959</u>
9. AGE (In years from birthday) yrs.	10. IF UNDER 1 YEAR Months <u>1</u>	11. IF UNDER 24 HRS. Days <u>7</u>	12. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Daniel A. Allen</u>		14. MOTHER'S MAIDEN NAME <u>Joan A. Knowski</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Daniel A. Allen (Father) Same as # 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> INTERVAL BETWEEN ONSET AND DEATH <u>491X</u>			
DUE TO Conditions, if any, which gave rise to immediate cause (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. <u>19</u>	Month, Day, Year p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Laurel Mem Park</u>
20f. (City or town) <u>Laurel</u>	(County) <u>Prince George</u>	(State) <u>Maryland</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John T. Maloney</u>	DATE SIGNED		
EXAMINER'S NAME (Type) <u>John T. Maloney, M.D.</u>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22b. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/12/59</u>	22c. NAME OF CEMETERY OR CREMATORIAL <u>Camer Mem Park</u>	22d. LOCATION (City, town, or county) <u>Maryland</u> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>DeWitt Donaldson, Laurel, Md</u>	ADDRESS <u>2033254 XV5</u>	24a. REC'D BY REGISTRAR <u>NOV 13 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Ernest S. Kraus</u>

WATER CHAMBERS - HENRY - DEATH
MEDICAL EXAMINER'S CERTIFICATE

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Subject

Date

Year

Age

Sex

Color

Size

Weight

Length

Skin color, texture, condition

Color

Size

Condition of body

External injuries

Internal organs

Causes of death

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										Reg. Dist. No. 12840							
12862 CERTIFICATE OF DEATH																	
1. PLACE OF DEATH a. COUNTY Prince George					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND					b. COUNTY Maryland							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly					c. LENGTH OF STAY IN 1b 2 days					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berwyn Heights							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital					e. STREET ADDRESS 8700 62 Avenue					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First Lillian	Middle	Lost	4. DATE OF DEATH	Month November	Day 12	Year 1959									
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-2-89	9. AGE (In years lost birthday) 70 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	Hours 0	Min. 0							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY own home			11. BIRTHPLACE (State or foreign country) Virginia			12. CITIZEN OF WHAT COUNTRY? United States								
13. FATHER'S NAME George W Bursey					14. MOTHER'S MAIDEN NAME Mary K Cloud												
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. none			INFORMANT Charles M Attick			Address College Park, Md.								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X										INTERVAL BETWEEN ONSET AND DEATH 2 days							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)			DUE TO Cerebral Hemorrhage			Cerebral Hemorrhage											
(c)			DUE TO Cerebral Hemorrhage						3 yr +								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D. 4713-Berwyn Rd			20f. (City or town) (County) (State) College Park, Md.								
21. I certify that I attended the deceased from 1958 , 19, to NOV , 19 59 , that I last saw the deceased alive on 11/12 1959 , and that death occurred at 6 PM , from the causes and on the date stated above.										ADDRESS (Street, city or town, state) College Park, Md.							
ACTUAL SIGNATURE Dr. Etienne										DATE SIGNED							
PHYSICIAN'S NAME (Type)		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial								22b. DATE THEREOF Nov 16, 1959		22c. NAME OF CEMETERY OR CREMATORIUM Ft Lincoln Cemetery		22d. LOCATION (City, town, or county) Colmar Manor, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons										ADDRESS Hyattsville Md.		24a. REC'D BY REGISTRAR DATE NOV 17 '59		24b. REGISTRAR'S SIGNATURE Wm. S. Knudsen			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12841

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending", in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1		12923										12841			
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)													
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STATE Maryland													
c. LENGTH OF STAY IN 1b		e. COUNT Dist. Heights													
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		f. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dist. Heights													
3. NAME OF DECEASED (Type or print)		First James		Middle Irving		Last Bagnet		4. DATE OF DEATH		Month Nov		Day 20		Year 1959	
5. SEX Male		6. COLOR OF RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Oct 19, 1956		9. AGE (In years lost birthday) 3 yrs.		IF UNDER 1 YEAR Months		IF UNDER 24 HRS Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME William Brusie Bagnet		14. MOTHER'S MAIDEN NAME Mary Wensdon													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mother Mary Bagnet, same as #2		Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]															
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)															
154.5															
DUE TO Acute congestive heart failure															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.															
(b) Congenital heart disease															
DUE TO															
(c)															
INTERVAL BETWEEN ONSET AND DEATH															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)															
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.															
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY		Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
Hour o. m. p. m.		19		While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .															
ACTUAL SIGNATURE James I. Boyd															
DATE SIGNED Nov 20, 1959															
EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>													
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 23 1959		22c. NAME OF CEMETERY OR CREMATORIUM CEDAR HILL CEMETERY		22d. LOCATION (City, town, or county) SUITLAND		(State) MD							
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co.		ADDRESS 517-11th St. S.E. Wash., D.C.		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Arthur S. Keay		DATE NOV 24 '59							

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12863

CERTIFICATE OF DEATH

Reg. Dist. No.

12842

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit Permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Riverdale</i>		b. COUNTY <i>P. G.</i>	
c. LENGTH OF STAY IN 1b <i>45 yrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Riverdale</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Leland Memorial</i>		d. STREET ADDRESS <i>4509 Riverdale Rd.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Virgil</i>	Middle <i>G. Baldwin</i>	Last
4. DATE OF DEATH	Month <i>11</i>	Day <i>6</i>	Year <i>1959</i>
5. SEX	6. COLOR OR RACE <i>M.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 11, 1890</i>
9. AGE (In years last birthday) <i>68 yrs.</i>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salesman.</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Heating</i>	11. BIRTHPLACE (State or foreign country) <i>Tenn.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	13. FATHER'S NAME <i>Dewey Baldwin</i>		
14. MOTHER'S MAIDEN NAME <i>Sue Milligan</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no; or unknown) <i>No</i>		
16. SOCIAL SECURITY NO. <i>578-07-1141</i>	17. INFORMANT <i>(son) Russell Y.</i>	Address <i>same.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. <i>coronary heart disease</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>6 day</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) <i>1822 Biltmore St NW Washington DC</i>
21. I certify that I attended the deceased from <i>Aug. 1930</i> to <i>Nov 6, 1959</i> , that I last saw the deceased alive on <i>Nov 5, 1959</i> , and that death occurred at <i>12:30 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Edgar E. Quayle</i>		ADDRESS (Street, city or town, state) <i>DATE SIGNED</i> <i>1822 Biltmore St NW Washington DC</i>	
PHYSICIAN'S NAME (Type) <i>Edgar E. Quayle</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11-9-59</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Ft Lincoln</i>
22d. LOCATION (City, town, or county) <i>Vladensburg, Md.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lee Funeral Home - Washington D.C.</i>		24a. REC'D BY REGISTRAR DATE <i>NOV 10 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

CERTIFICATE OF DEATH

PAGE 2

NAME
MATERIALNAME
ADDRESS

NAME

EXPLANATION OF DEATH CERTIFICATE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12864

CERTIFICATE OF DEATH

Reg. Dist. No.

12843

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Prince George's</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Pr. George's Co.</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Laurel</i>		c. LENGTH OF STAY IN 1b <i>53 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>41 Laurel</i>		d. STREET ADDRESS <i>421 Pr. George St</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>421 Pr. George St</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <i>Bessie Burns Beall</i>		First <i>Bessie</i>	Middle <i>Burns</i>	Last <i>Beall</i>	4. DATE OF DEATH <i>March 3</i>		Month <i>March</i>	Day <i>3</i>	Year <i>1959</i>	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 10, 1880</i>		9. AGE (In years lost birthday) yrs. <i>79</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Hours <i>0</i>	Day <i>0</i>	Year <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>		11. BIRTHPLACE (State or foreign country) <i>Annapolis, Md., U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				
13. FATHER'S NAME <i>Charles S. Burns</i>		14. MOTHER'S MARRIED NAME <i>Louise Hosley</i>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Mr. W. E. Beall, 421 Prince St., Laurel, Md.</i>		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cancer of Breast</i>		DUE TO <i>170X</i>				INTERVAL BETWEEN ONSET AND DEATH <i>10 years</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) (c)		DUE TO								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/> <i>at work</i>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>421 Prince St.</i>		20f. (City or town) (County) <i>Laurel, Md.</i>		(State) <i>Md.</i>		
21. I certify that I attended the deceased from <i>March 1, 1949, to November 3, 1959</i> , that I last saw the deceased alive on <i>November 2, 1959</i> , and that death occurred at <i>8 A.M.</i> from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>Laurel, Md.</i>		DATE SIGNED		
ACTUAL SIGNATURE <i>Robert S. McCeney</i>		M.D.								
PHYSICIAN'S NAME (Type) <i>Robert S. McCeney</i>		I, laurel, Md.								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11/5/59</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Laurel Family Cem. Savage Md.</i>		22d. LOCATION (City, town, or county) <i>Savage, Md.</i>		(State) <i>Md.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>DeWitt Danaldson, Laurel, Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE NOV 9 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>				

CERTIFICATE OF DEATH

Date of Birth

Name
Husband

Signature

Signature of Physician

Signature

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12924 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12844

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince George</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Pr. Geo</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Dale</i>	c. LENGTH OF STAY IN 1b <i>50 years</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Dale</i>	d. STREET ADDRESS <i>3 Bell Station Road</i>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>1 Bell Station Road</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Sillian</i>	First <i>Sillian</i>	Middle <i>Beall</i>	Last <i>Beall</i>
4. DATE OF DEATH <i>Nov. 17 1959</i>	Month <i>Nov.</i>	Day <i>17</i>	Year <i>1959</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-23-1879</i>
9. AGE (In years (at birthday) yrs. <i>79</i>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>	10b. KIND OF BUSINESS OR INDUSTRY <i></i>	11. BIRTHPLACE (State or foreign country) <i>Md.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	13. FATHER'S NAME <i>William J. Beall</i>		
14. MOTHER'S MAIDEN NAME <i>Walter Amanda Beall.</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		
16. SOCIAL SECURITY NO. <i></i>	17. INFORMANT <i>Niota C. Beall - Same address</i>	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0</i>			
DUE TO <i>Congestive heart failure</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic heart disease</i>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>John T. Maloney</i>		DATE SIGNED <i>Nov. 17 1959</i>	
EXAMINER'S NAME (Type) <i>John T. Maloney, M.D.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Nov 21, 1959</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Holy Trinity Cemetery</i>		22d. LOCATION (City, town, or county) <i>Collington Md.</i>	
(State)		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gasch's Sons</i>		24a. REC'D. BY REGISTRAR NOV 23 '59	
ADDRESS <i>Hyattsville, Md.</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	
DATE			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12853

CERTIFICATE OF DEATH

Reg. Dist. No.

12845

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY Thorton ✓	
b. CITY, OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Md		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING 1556-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Blue Branch Nursing Home		d. STREET ADDRESS 4718 GLEN OAK RD.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED First AUGUST Middle H BECKER		4. DATE OF DEATH 11 - 19 - 1959	
5. SEX MALE COLOR OR RACE WHITE		6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. B. DATE OF BIRTH Oct 26, 1867		8. AGE (In years last birthday) 92 yrs.	
9. IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED TAILOR	
10b. KIND OF BUSINESS OR INDUSTRY TAILOR		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME August H. Becker	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Julius T. Becker Rd 1 Annandale Va	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO ACUTE PULMONARY EDEMA INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) CORONARY INSUFFICIENCY DUE TO		8 hrs.	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-27, 1951, to 11-19, 1959, that I last saw the deceased alive on 11-19, 1959, and that death occurred at 4:50 M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) M.D. 6480 N.H. AVE - TAKOMA PARK MD. DATE SIGNED 11/19/59	
ACTUAL SIGNATURE R.C. KIRCHNER		PHYSICIAN'S NAME (Type) R.C. KIRCHNER	
22e. BURIAL, CREMATION, REMOVAL (Specify) Burial		22f. DATE THEREOF 11-21-59	
22g. NAME OF CEMETERY OR CREMATORIAL PROSPECT HILL		22h. LOCATION (City, town, or county) Washington DC (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Deaf Funeral Home		24a. REC'D BY REGISTRAR NOV 24 '59	
ADDRESS 4812 Gaithersburg Wash. DC		24b. REGISTRAR'S SIGNATURE Arthur S. Hunt	

2010年1月1日-2010年12月31日

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12865

CERTIFICATE OF DEATH

Reg. Dist. No.

12846

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE VIRGINIA b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAUREL	c. LENGTH OF STAY IN lb ach. 9-22-59	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAXES CHURCH 83X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LAUREL SANITARIUM	d. STREET ADDRESS 918 SPRING LANE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) GERTRUDE	First	Middle	Last
S. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-23-1884
9. AGE (In years lost birthday) 75 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. Year Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GUR. EMPLOYEE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE W. DEER		14. MOTHER'S MAIDEN NAME MARY L. YOUNG.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Records LAUREL SANITARIUM		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO arteritis arteritic lieut dicouse (420) several yrs?		ONSET AND DEATH few hrs	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Scuile Demunition (arteritis arteritic) sumur of salury		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) shard (left)	
20c. TIME OF INJURY Hour p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 9-22-1959 to 11-26-1959, that I last saw the deceased alive on 11-26-1959, and that death occurred at 4:50 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) LAUREL SANITARIUM 11-26-59	
ACTUAL SIGNATURE ERIKA P. KRAMMER		DATE SIGNED 11-26-59	
PHYSICIAN'S NAME (Type) ERIKA P. KRAMMER		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 11/26/59	
22c. NAME OF CEMETERY OR CREMATORIAL COLUMBIA GARDENS		22d. LOCATION (City, town, or county) ARLINGTON, VA (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Erroll J. Schenck 3524 Columbia Pike		ADDRESS Arlington, VA	
24a. REC'D BY REGISTRAR NOV 30 1959		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 3 should be detached for use as the burial-transit Permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

DEATH

NAME OF DECEASED		ADDRESS OF DECEASED	
JAMES HENRY COOPER		101 E. 36TH ST.	
BOSTON, MASS.		BOSTON, MASS.	
AGE AT DEATH		TIME OF DEATH	
66		10:00 A.M.	
SEX		MATERIAL TESTED	
MALE		BLOOD	
CAUSE OF DEATH		METHOD OF DETERMINATION	
HEART DISEASE		AUTOPSY	
TIME OF DEATH		TIME OF AUTOPSY	
10:00 A.M.		10:00 A.M.	
NAME OF DOCTOR		NAME OF HOSPITAL	
DR. JAMES HENRY COOPER		HOSPITAL OF THE UNIVERSITY OF MARYLAND	
TIME OF AUTOPSY		TIME OF REPORT	
10:00 A.M.		10:00 A.M.	
NAME OF ATTENDING PHYSICIAN		NAME OF PATHOLOGIST	
DR. JAMES HENRY COOPER		DR. RICHARD W. BROWN	
TIME OF REPORT		TIME OF DEATH	
10:00 A.M.		10:00 A.M.	
NAME OF CLERK		NAME OF CLERK	
DR. JAMES HENRY COOPER		DR. RICHARD W. BROWN	
TIME OF DEATH		TIME OF REPORT	
10:00 A.M.		10:00 A.M.	

12925

CERTIFICATE OF DEATH

Reg. Dist. No.

12847

1. PLACE OF DEATH o. COUNTY PRINCE GEORGES			MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE DISTRICT OF COLUMBIA b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON, D.C.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL ANDREWS			d. STREET ADDRESS 1104 MISSISSIPPI AVE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <i>George E. Randall</i>	Middle <i>Male</i>	Last <i>BESOSA</i>	4. DATE OF DEATH <i>November 28 1959</i>
S. SEX <i>Female</i>	6. COLOR OR RACE <i>Caucasian</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <i>28 Nov. 1959</i>	9. AGE (In years last birthday) <i>Newborn/yr.</i>
8. SEX <i>N/A</i>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>N/A</i>	
10b. KIND OF BUSINESS OR INDUSTRY <i>N/A</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME JORGE BESOSA RAMIREZ			14. MOTHER'S MAIDEN NAME DOROTHY CARTER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	INFORMANT FROM CHART	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>Prematurity</i> DUE TO <i>Respiratory Failure</i> INTERVAL BETWEEN ONSET AND DEATH <i>1 hr 45 min</i>				
Conditions, if any, which gave rise to immediate cause (o), stating the under-lying cause lost. <i>773.5</i>		(b) <i>Prematurity</i> DUE TO <i>Respiratory Failure</i>	(c) <i>Respiratory Failure</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 28 Nov 1959 , to 28 Nov 1959 , that I last saw the deceased alive on 28 November 1959 , and that death occurred at USAF Hospital Andrews , from the causes and on the date stated above.				
ACTUAL SIGNATURE <i>George E. Randall</i>		M.D.	ADDRESS (Street, city or town, state) USAF HOSPITAL ANDREWS	
DATE SIGNED 28 Nov 59				
PHYSICIAN'S NAME (Type) GEORGE E RANDALL, CAPT, USAF, MC		USAF HOSPITAL ANDREWS, ANDREWS AFB, MD		
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	22b. DATE THEREOF 30 Nov 59	22c. NAME OF CEMETERY OR CREMATORIAL D.C. Morgue	22d. LOCATION (City, town, or county) WASHINGTON D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	24a. REC'D BY REGISTRAR DATE DEC 1 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Krause



CHINESE LIBRARY OF THE UNIVERSITY OF TORONTO LIBRARIES

STANLEY CHAPMAN

卷之三

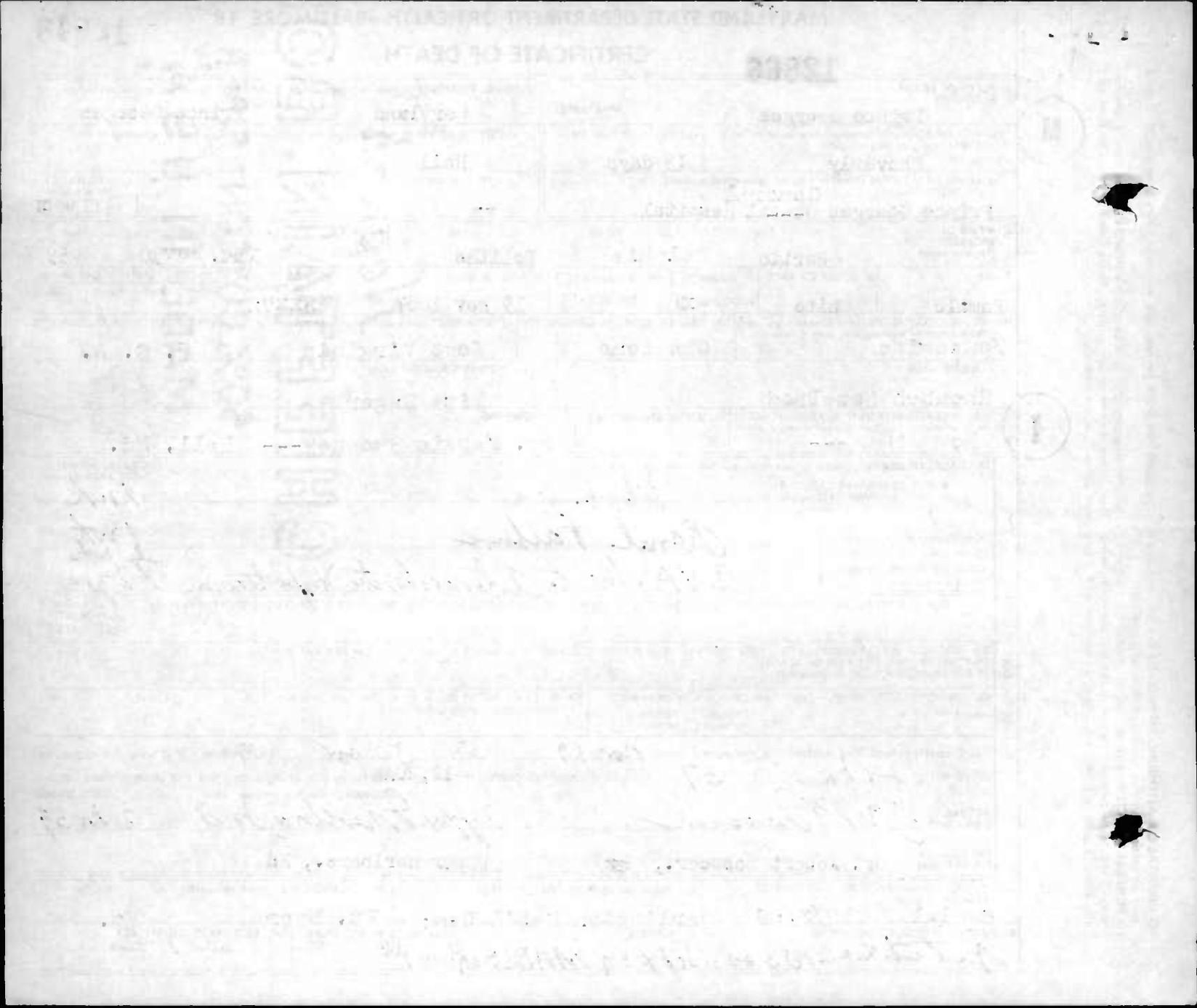
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be retained by the hospital or attending physician.
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 12848

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 13 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hall		d. STREET ADDRESS ---	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION General Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Bertie	Middle Delphia	Last Bolithe	4. DATE OF DEATH	Month Nov	Day 30	Year 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 19 Nov 1887	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months ---	IF UNDER 24 HRS. Days ---	Hours ---
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Rheuben Nazelrod		14. MOTHER'S MAIDEN NAME Eliza Sager		INFORMANT Mrs. Margie Sweeney Address Hall, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Vivensea INTERVAL BETWEEN ONSET AND DEATH 1 wk							
CANDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. (b) Renal Failure 1 wk							
DUE TO (c) CVA due to Arteriosclerotic Hypertension 2 wks 72 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mar 17 , 1959, to 30 Nov , 1959, that I last saw the deceased alive on 29 Nov , 1959, and that death occurred at 12, 20 AM from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) Upper Marlboro, Md DATE SIGNED 30 Nov 59							
ACTUAL SIGNATURE R. M. Sasscer							
PHYSICIAN'S NAME (Type) Dr. Robert Sasscer, MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/3/59		22c. NAME OF CEMETERY OR CREMATORIAL Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Ft. Myer Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Patchie Bass, Upper Marlboro							
ADDRESS DEC 7 '59 24a. REC'D BY REGISTRAR Arthur S. Kraus 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

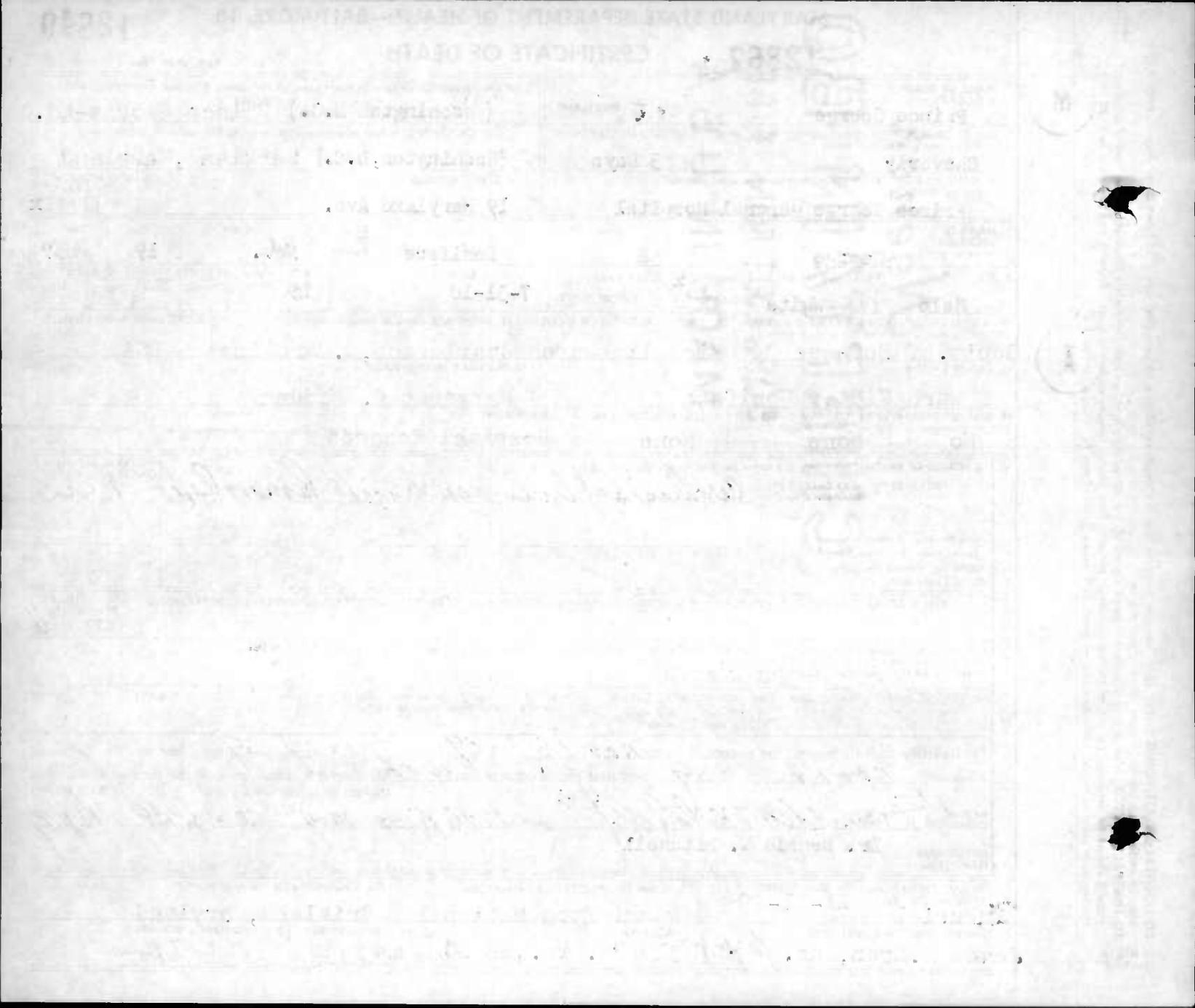
12867

CERTIFICATE OF DEATH

Reg. Dist. No.

12849

1. PLACE OF DEATH o. COUNTY Prince George		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE (Washington D.C.) Prince George-Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 3 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First George	Middle B	Last Boniface
4. DATE OF DEATH	Month Nov.	Day 19	Year 19 59
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-31-10
9. AGE (In years at birthday) 49 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dep't. of Defense	11. KIND OF BUSINESS OR INDUSTRY Missel Research	12. BIRTHPLACE (State or foreign country) Charleston, S. Carolina
13. FATHER'S NAME Edward Victor Boniface	14. MOTHER'S MAIDEN NAME Margaret G. Madden	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. None	INFORMANT Hospital Records	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Hour o. m. p. m.	Month, Doy, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov 16, 1959 , to Nov 19, 1959 , that I last saw the deceased alive on Nov 19, 1959 , and that death occurred at 10:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Donald W. Mitchell</i>	ADDRESS (Street, city or town, state) M.D. 1746 N. St. 2100, Washington, D.C. 20501		DATE SIGNED 11/19/59
PHYSICIAN'S NAME (Type) Dr. Donald W. Mitchell			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-21-59	22c. NAME OF CEMETERY OR CREMATORIUM Washington National	22d. LOCATION (City, town, or county) Suitland, Maryland (State)
23. FUNERAL DIRECTOR'S SIGNATURE James T. Ryah, Inc.	ADDRESS 317 Pa. Ave., SE DC	24a. REC'D BY REGISTRAR NOV 23 1959	24b. REGISTRAR'S SIGNATURE Arthur S. Knaus



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12850

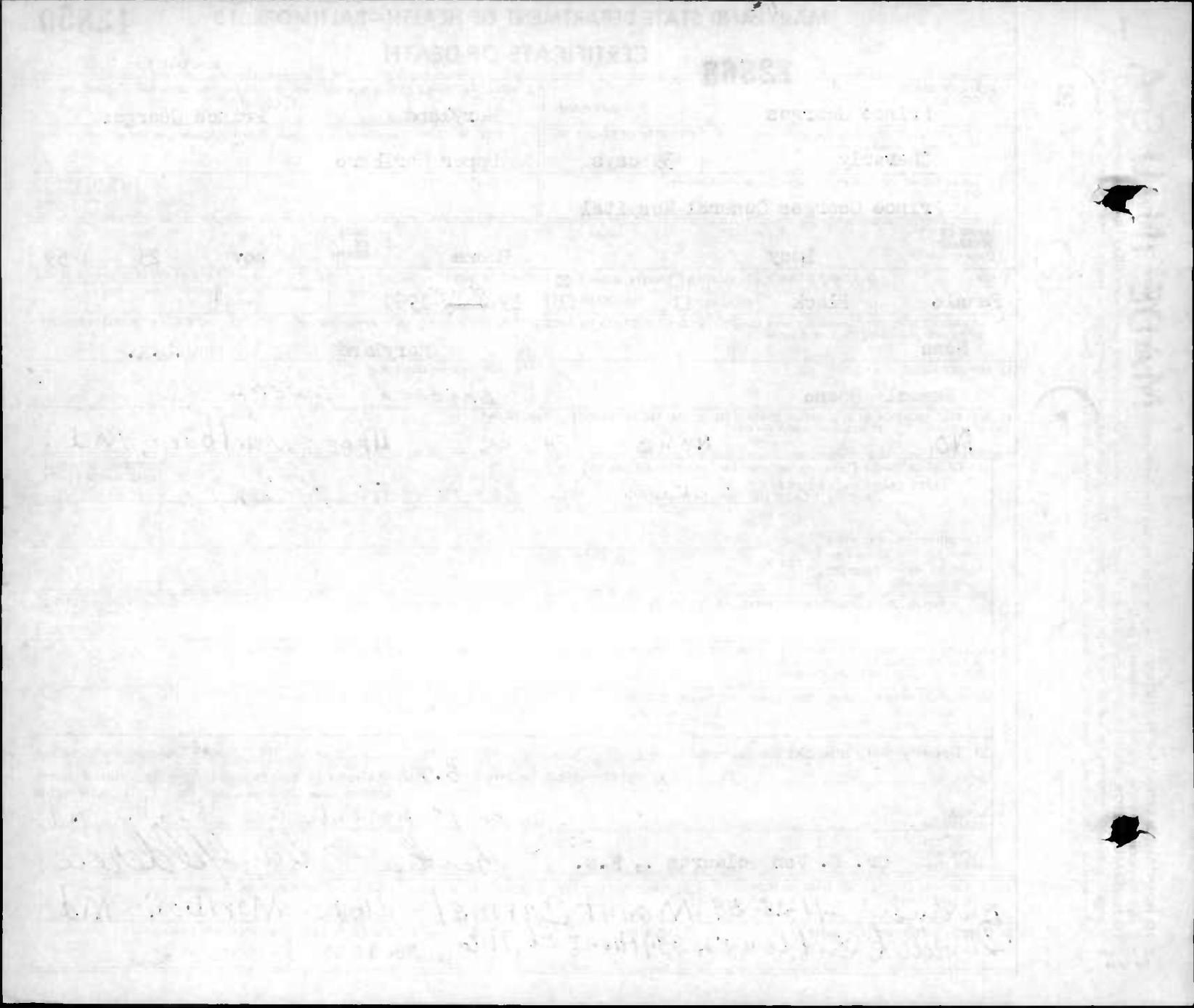
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 39 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Lucy	Middle	Last Boone
4. DATE OF DEATH	Month Nov	Day 25	Year 1959
S. SEX Female	6. COLOR OR RACE Black	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 19 AUG 1959
9. AGE (In years lost birthday) yrs. 4	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME Samuel Boone		
14. MOTHER'S MAIDEN NAME BARBARA OWENS	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. None	INFORMANT FATHER	Address Upper Marlboro, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGENITAL Polycystic Kidneys DUE TO 757.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at 5:00 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE		ADDRESS (Street, city or town, state) M.D. 3001 Cheverly Ave Cheverly, Md.	
PHYSICIAN'S NAME (Type) Dr. B. Van Gelderen, M.D.		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-28-59	22c. NAME OF CEMETERY OR CREMATORIAL Mount Carmel	22d. LOCATION (City, town, or county) (State) Upper Marlboro, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Dorothy R. Collins	ADDRESS 4339 Hunt Rd., N.E.	24a. REC'D BY REGISTRAR DATE NOV 30 '59	24b. REGISTRAR'S SIGNATURE Orpha S. Traas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12869

CERTIFICATE OF DEATH

Reg. Dist. No.

12851

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges		2. USUAL RESIDENCE <small>(Where deceased lived. If institution, Residence before admission)</small> a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 21 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles	First Charles	Middle A.	Last Brown
4. DATE OF DEATH Nov. 7 1959	Month Nov.	Day 7	Year 59
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-6-68
9. AGE (In years lost at birth) 91 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carpenter	11. KIND OF BUSINESS OR INDUSTRY Houses	12. BIRTHPLACE (State or foreign country) D.C.
13. FATHER'S NAME Charles Brown	14. MOTHER'S MAIDEN NAME Sarah Daugherty		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No	16. SOCIAL SECURITY NO. None	INFORMANT John Elizabeth Vermillion	Address Same as # 2
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anemone right lung <small>733X</small> <small>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</small> <small>(b) fracture left ribs Pathologal</small> <small>(c)</small> <small>DEATH DUE TO</small> <small>DEATH DUE TO</small> <small>DEATH DUE TO</small> <small>INTERVAL BETWEEN ONSET AND DEATH</small> <small>11-3-59</small>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <small>(IF EITHER, NOTIFY MEDICAL EXAMINER)</small>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Moving back + fell in bed, pathologic		
20c. TIME OF INJURY Month, Day, Year 3 Hour a. m. 10-17 189	20d. INJURY OCCURRED While Not while <small>at work</small> <input type="checkbox"/> <small>at work</small> <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Colmar Manor (County) Md. (State)
21. I certify that I attended the deceased from 10-17 , 189, to 11-7 , 189, that I last saw the deceased alive on 11-7 , 189, and that death occurred at 12:19 p.m. from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. G. Hageage	ADDRESS (Street, city or town, state) 3217-38 1/2 Ce		
PHYSICIAN'S NAME (Type) Dr. G. Hageage	DATE SIGNED 11-7-59		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/10/59	22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	22d. LOCATION (City, town, or county) Colmar Manor (State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons	ADDRESS Hyattsville, Md.	24a. REC'D BY REGISTRAR NOV 10 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kline

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be retained by the hospital or attending physician.
Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12852

CERTIFICATE OF DEATH

Reg. Dist. No. _____

1. PLACE OF DEATH a. COUNTY Prince Georges		2. USUAL RESIDENCE Maryland deceased lived. If institution, Residence before admission a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake		c. LENGTH OF STAY IN 1b 20 min.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cedar Heights	
3. NAME OF DECEASED (Type or print) Rosa		4. DATE OF DEATH Nov. 28, 1959	
5. SEX Fem.	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-2-16
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic	10b. KIND OF BUSINESS OR INDUSTRY Housework	11. BIRTHPLACE (State or foreign country) Md.	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME James H. Brown		14. MOTHER'S MAIDEN NAME Emma L. Green	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. INFORMANT Marie Tilghman-sister	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Bronchopneumonia DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. _____		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) Washington (County) D.C. (State) 1959	
21. I certify that I attended the deceased from Nov. 28, 1959 , to Nov. 28, 1959 , that I last saw the deceased alive on Nov. 28, 1959 , and that death occurred at 9:10A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Ronald S. Fleischer		ADDRESS (Street, city or town, state) 1732 Benet Lee Rd. DATE SIGNED 1/29/59	
PHYSICIAN'S NAME (Type) Ronald S. Fleischer		22a. BURIAL CREMATION, REMOVAL (Specify) 12-2-59 22b. DATE THEREOF 12-2-59 22c. NAME OF CEMETERY OR CREMATORIAL Mount Olivet 22d. LOCATION (City, town, or county) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Henry J. Washington		ADDRESS 467 N st NW 24a. RECEIVED BY REGISTRAR DEC 4 '59 24b. REGISTRAR'S SIGNATURE Arthur S. Krause	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12871

CERTIFICATE OF DEATH

Reg. Dist. No.

12853

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 7 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Washington D.27		d. STREET ADDRESS 7191 Ritchie St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Alice	First	Middle	Last	4. DATE OF DEATH Bryant	Month	Day	Year
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday) 67 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife at Home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Lewis		14. MOTHER'S MAIDEN NAME Lorraine Green					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		INFORMANT		Address Grace Hunt 6204 L st Nw	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260x Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Bronchopneumonia, acute (b) Diabetes mellitus DUE TO (c) Generalized arteriosclerosis DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis DUE TO INTERVAL BETWEEN ONSET AND DEATH (weeks)							
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) While at work		20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 4, 1959 , to Nov. 11, 1959 that I last saw the deceased alive on November 11, 1959 , and that death occurred at 9:40 AM , from the causes and on the date stated above. ACTUAL SIGNATURE Till Bergmann PHYSICIAN'S NAME (Type) Dr. Till Bergmann ADDRESS (Street, city or town, state) 4314 Falls Rd. Nw, Bethesda DATE SIGNED Nov. 11, 1959							
22a. BURIAL, CREMATION, REMOVAL (Specify) 114659	22b. DATE THEREOF 114659	22c. NAME OF CEMETERY OR CREMATORIAL Mt Carmel	22d. LOCATION (City, town, or county) Elmwood Mausoleum				
23. FUNERAL DIRECTOR'S SIGNATURE Henry J. Washington	ADDRESS 467 N st NW	24a. REC'D BY REGISTRAR DATE NOV 18 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Evans				

January 10th 1924
Afternoon

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G255 12/3/59 iwk

12854

12872

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
PRINCE GEORGE MARYLAND		MARYLAND PRINCE GEORGE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
LAUREL		atm. April 3-56	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS	
LAUREL SANITARIUM		LAUREL 4 386 MAIN STREET	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
DORA		H	BYERLY
4. DATE OF DEATH		Month	Day
NOV. 27		Year	1959
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
FEMALE		WHITE	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH		9. AGE (In years lost birthday)	10. IF UNDER 1 YEAR Months Days Hours Min.
Oct. 21-1874		85 yrs.	
10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
HOUSEWIFE		Hause	NEW YORK
12. CITIZEN OF WHAT COUNTRY?		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
JAMES HERBERT CLARK		MARY ADELAIDE BONDY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT
Unknown			Hospital RECORDS LAUREL SANITARIUM
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0		Congestive heart failure (434.1) 3 months	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		Anterior atherosclerotic heart disease (429.0) many years	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1956 to Nov. 27 1959, that I last saw the deceased alive on Nov. 27 1959, and that death occurred at 8 th M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE		Laurel Sanitarium 11-27-59	
PHYSICIAN'S NAME (Type)		ERIKA P. KRAEMER LAUREL MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		Dec 1 1959	
22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county) (State)	
Burlington National		Burlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
He Witt Hanford		Laurel Md	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE DEC 1 '59		Arthur S. Kraemer	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar, prior to burial, cremation, or removal, and in any event within 72 hours after death.

81. SPONSORSHIP-FINANCIAL STATEMENT (CONTINUED)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12873

CERTIFICATE OF DEATH

12855

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Prince George's				a. STATE Maryland Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Capitol Heights		c. LENGTH OF STAY IN 1b 10 years		b. COUNTY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 807 58th Avenue				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Capitol Heights	
3. NAME OF DECEASED (Type or print)		First Sophie	Middle M.	Last Cahill	4. DATE OF DEATH Month Nov. Day 12 Year 1959
5. SEX F		6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 8-8-1890	9. AGE (In years last birthday) 69 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Germany	
13. FATHER'S NAME Herman Rosenfeld		14. MOTHER'S MAIDEN NAME BERTHA STERIN		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 493-27-0582		17. INFORMANT John J Cahill Address 807 58th Ave. Capitol Heights Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		generalized Metastasis Adenocarcinoma of rectum			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Day	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from		September 1957, to 11-12-1959, that I last saw the deceased alive on 11-12-1959, and that death occurred at 11 P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE PETER DUUS		ADDRESS (Street, city, or town, state) 6124 Central Av. Capitol Heights Md DATE SIGNED 11-12-59			
PHYSICIAN'S NAME (Type) PETER DUUS					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/16/59	22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		22d. LOCATION (City, town, or county) Washington, D.C. (State)
23. FUNERAL DIRECTOR'S SIGNATURE The S.H.Hines Co. - 2901 14th St. N.W. Washington, D.C.		ADDRESS 14th St. N.W. Washington, D.C.	24a. REC'D BY REGISTRAR NOV 16 '59		24b. REGISTRAR'S SIGNATURE Arthur & Krause

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12856

12874

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eugene Leland Memorial Hospital				d. STREET ADDRESS 11426 Cherry Hill Road				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME DECEASED (Type or print)		First Merry	Middle Violet	Last Christine A.	4. DATE OF DEATH November 16 1959	Month November	Day 16	Year 1959
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 4-7-11	9. AGE (In years last birthday) 4 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Virginia		
12. CITIZEN OF WHAT COUNTRY? U.S.								
13. FATHER'S NAME George W. Carroll				14. MOTHER'S MAIDEN NAME Cora Lee Lipstrap				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>				16. SOCIAL SECURITY NO. 215-38-3386				
17. INFORMANT Hospital Record				Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. } (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH uterine Cachexia and hemorrhage Carcinoma of the cervix of uterus				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 7-11, 1959, to 11-16, 1959, that I last saw the deceased alive on 11-16, 1959, and that death occurred at 9:03 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Theodore Zegarra, M.D. M.D. 11-16-59								
PHYSICIAN'S NAME (Type) Theodore Zegarra M.D., 4404 Queensbury Rd., Riverdale, Maryland								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/19/59		22c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln		22d. LOCATION (City, town, or county) Colmar Manor, Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Nallely's Funeral Home, Inc.				ADDRESS Mt. Rainier, Md.		24a. REC'D BY REGISTRAR DATE NOV 20 '59		
VS A15 (4) 15M 9/55						24b. REGISTRAR'S SIGNATURE S. Clark		

81. BROWNSTONE-2011A30430-TWINSBURG-STATES-GLENDALE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12875

CERTIFICATE OF DEATH

12857

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY

Prince Georges

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cheverly

c. LENGTH OF STAY IN 1b

8 hrs

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE

Maryland

b. COUNTY

Prince Georges

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

33 Bladensburg

d. STREET ADDRESS

1909 Quincy Street

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4.

DATE
OF
DEATH

Month

Day

Year

Carter

Nov

18

1959

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

9. AGE (In years
last birthday)

yrs.

IF UNDER 1 YEAR

Months

IF UNDER 24 HRS.

Days

Male

White

9 Feb 1909

50

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

Mechanic

Auto Body

Yancy County, N.C.

USA

13. FATHER'S NAME

Robert Eugene Carter

14. MOTHER'S MAIDEN NAME

Clara Blankenship

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

No

(If yes, give year or dates of service)

None

16. SOCIAL SECURITY NO.

Unknown

INFORMANT

Ernest E. Carter, 4909 Quincy St., Bladensburg, Md.

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

492X

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

(c)

Baclochopneumonia with abscess formation

INTERVAL BETWEEN
ONSET AND DEATH

Malnutrition

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19 p. m.20d. INJURY OCCURRED
While at work Nat while
of work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from Nov. 18, 1959, to Nov. 18, 1959, that I last saw the deceased
alive on Nov. 18, 1959, and that death occurred at 5:50 A.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

Raedl Fischer MD 5432 Queen Chapel Rd

PHYSICIAN'S
NAME (Type)

Ronald S. FLEISCHER MD a doctor and 11/19/59

22a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial

22b. DATE THEREOF

Nov. 21/1959

22c. NAME OF CEMETERY OR CREMATORIUM

Unknown

22d. LOCATION (City, town, or county)

Asheville, N.C.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

W. J. Chambers, Riverdale, Md.

ADDRESS

24a. REC'D BY REGISTRAR

NOV 24 '59

24b. REGISTRAR'S SIGNATURE

Arthur S. Kress

DATE

W. J. Gandy
New Mex. Geol. Surv.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12858

Reg. Dist. No.

12875

1. PLACE OF DEATH
o. COUNTY

Prince George's MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cheverly

c. LENGTH OF STAY IN 1b

Dead on arrival

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

d. STATE Maryland

b. COUNTY Prince George's

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Upper Marlboro X

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Prince George's General Hospital

d. STREET ADDRESS

Main Street

e. IS RESIDENCE ON A FARM?

YES NO

3. NAME OF
DECEASED
(Type or print)

First
Carry

Middle
Mable

Last
Chaney

4. DATE
OF
DEATH

Month
November
Year
30, 1959

Day
Month
Days
Year
1959
11
30
1959

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED
WIDOWED DIVORCED

8. DATE OF BIRTH

June 13, 1886

9. AGE (In years
last birthday
73 yrs.)

IF UNDER 1 YEAR
Month Days
IF UNDER 24 HRS.
Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Henry Sears

14. MOTHER'S MAIDEN NAME

Ella - ? - Last name unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

Address
Louis Henry Chaney, Upper Marlboro, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Acute congestive heart failure

INTERVAL BETWEEN
ONSET AND DEATH

442X

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause lost.

DUE TO

(b)

Cardiovascular renal disease

(c)

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

19. WAS AUTOPSY
PERFORMED?
YES NO

20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m.

20d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .

ACTUAL
SIGNATURE

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

James I. Boyd

November 39, 1959

22a. BURIAL, CREMATION, REMOVAL (Specify) 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORIUM 22d. LOCATION (City, town, or county) (State)

Burial

12/3/59

Smithville Cemetery

Smithville Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE

Ritchie Bros. Funeral Home-

Upper
Marlboro, Md.

DEC 7 1959
DATE

Arthur S. Maule

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 10a, 10b & 22b, Film G-253 12/8/59.cac. Reg. Dist. No.

13996

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Connecticut b. COUNTY Hartford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) T.B.		c. LENGTH OF STAY IN 1b Transient	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Dobson's Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manchester Green 45 x .3	
3. NAME OF DECEASED (Type or print) AARON		First MIDDLE (N.M.N.) COOK	4. DATE OF DEATH Month November Day 11th, Year 19 59
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 6th, 1909
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Security Trader see below		10b. KIND OF BUSINESS OR INDUSTRY Brokerage (see below)	
13. FATHER'S NAME Arthur Cook		14. MOTHER'S MAIDEN NAME Jennie Luce	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Mrs. Elizabeth L. Cook, 562 E. Middle Tpk. Manchester Green, Conn.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442 X DUE TO Acute congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Cardio-vascular renal disease (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>James I. Boyd</i> DATE SIGNED EXAMINER'S NAME (Type) James I. Boyd M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 22b. DATE THEREOF Burial Nov. 18, 1959.			
22c. NAME OF CEMETERY East Cemetery		22d. LOCATION (City, town, or county) Manchester, Connecticut (State)	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. CHAMBERS CO., Riverdale, Maryland.		24a. REC'D BY REGISTRAR DATE NOV 16 '59	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur & Thane	

STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE
DEPARTMENT
OF HEALTH

NAME: John F. Kennedy
ADDRESS: 1600 Pennsylvania Avenue, N.W., Washington, D.C.

CAUSE OF DEATH: Gunshot wound

TIME OF DEATH: 12:45 P.M.

AGE AT DEATH: 43 years

SEX: Male

RACE: White

WEIGHT: 180 lbs.

HEIGHT: 5'10"

HAIR COLOR: Dark brown

EYE COLOR: Brown

CLOTHING: Suit jacket, white shirt, tie, dark trousers

ACCESSORIES: No hat or coat

EXAMINER'S SIGNATURE: John F. Kennedy

EXAMINER'S ADDRESS: 1600 Pennsylvania Avenue, N.W., Washington, D.C.

EXAMINER'S PHONE NUMBER: (202) 455-1000

EXAMINER'S SIGNATURE: John F. Kennedy

EXAMINER'S ADDRESS: 1600 Pennsylvania Avenue, N.W., Washington, D.C.

EXAMINER'S PHONE NUMBER: (202) 455-1000

EXAMINER'S SIGNATURE: John F. Kennedy

EXAMINER'S ADDRESS: 1600 Pennsylvania Avenue, N.W., Washington, D.C.

EXAMINER'S PHONE NUMBER: (202) 455-1000

EXAMINER'S SIGNATURE: John F. Kennedy

EXAMINER'S ADDRESS: 1600 Pennsylvania Avenue, N.W., Washington, D.C.

EXAMINER'S PHONE NUMBER: (202) 455-1000

EXAMINER'S SIGNATURE: John F. Kennedy

EXAMINER'S ADDRESS: 1600 Pennsylvania Avenue, N.W., Washington, D.C.

EXAMINER'S PHONE NUMBER: (202) 455-1000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
1982 CERTIFICATE OF DEATH

12859

Reg. Dist. No.

12877

1. PLACE OF DEATH a. COUNTY <i>P. George</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>P. George</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brentwood.</i>		c. LENGTH OF STAY IN 1b <i>20 yrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brentwood.</i>		d. STREET ADDRESS <i>3704 Taylor St.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>3704 Taylor St.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Bertha</i>	Middle <i>P.</i>	Last <i>Cusick</i>	4. DATE OF DEATH	Month <i>Nov.</i>	Day <i>27</i>	Year <i>1959</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>Nov. 19 1888</i>	9. AGE (In years last birthday) <i>71 yrs.</i>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>H-Wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>		11. BIRTHPLACE (State or foreign country) <i>Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Alexander Raedy</i>		14. MOTHER'S MAIDEN NAME <i>Maggie</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>John R. Cusick, Jr.</i>		Address <i>Somers #2.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>332x</i>		Cerebral Thrombosis		INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <i>Tenently adenocarcinoma</i>				5 years			
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>3701 Leland St., Chevy Chase, Md.</i>	(County) <i>Montgomery Co., Md.</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>Mar. 15, 1957</i> , to <i>Dec. 27, 1957</i> , that I last saw the deceased alive on <i>Dec. 26, 1957</i> , and that death occurred at <i>11 AM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>3701 Leland St., Chevy Chase, Md.</i> DATE SIGNED <i>11-17-57</i>							
ACTUAL SIGNATURE <i>J. Raymond Raedy</i>		M.D.					
PHYSICIAN'S NAME (Type) <i>J. Raymond Raedy</i>		3701 Leland St., Chevy Chase, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11-30-1959</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>FT Lincoln Cemetery</i>		22d. LOCATION (City, town, or county) <i>Bladensburg</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W.W. Chambers Co.</i>		ADDRESS <i>5801 Cleveland Ave Riverdale, Md.</i>		24a. REC'D. BY REGISTRAR <i>DEC 1. '59</i>		(State) <i>Md.</i>	
						24b. REGISTRAR'S SIGNATURE <i>Orlina S. Raedy</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retyped by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12927

CERTIFICATE OF DEATH

Reg. Dist. No.

12860

1. PLACE OF DEATH a. COUNTY Prince Georges¹		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL—Upper Marlboro		c. LENGTH OF STAY IN 1b 50 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —		X d. STREET ADDRESS RURAL—Upper Marlboro	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED Stella /First Juilette Middle		4. DATE OF DEATH Month Day Year Nov 22 1959	
5. SEX Female White		6. COLOR OR RACE WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 11, 1884	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife-Tobacco Farming		10b. KIND OF BUSINESS OR INDUSTRY Own Home-Farm	
11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT Edward E. Danenhower, Jr.—Maryland;		Address Upper Marlboro	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 2 mo.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Arteriosclerotic Coronary Disease		(c) 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 17 Nov , 1959, to Nov 22 , 1959, that I last saw the deceased alive on Nov 26 , 1959, and that death occurred at 108 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE R. B. Sasscer		ADDRESS (Street, city or town, state) Upper Marlboro, Md	
PHYSICIAN'S NAME (Type) R. B. Sasscer, M.D.		DATE SIGNED 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/30/59	
22c. NAME OF CEMETERY OR CREMATORIUM Rock Creek Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Funeral Home—Marlboro, Md.		ADDRESS Upper	
		24a. REC'D BY REGISTRAR DATE DEC 1 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

100 FRONTAGE ROAD, DUNMUIR, B.C. V0J 1G0 (250) 492-2222

X. 1
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 12928 CERTIFICATE OF DEATH 12861

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince George's Co.</i> <i>4402 72nd Ave.</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> <i>Pr. Geo. Co.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Landover Hills, Md.</i>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Landover Hills</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <i>4402 62nd Ave.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First <i>Isabel</i>	Middle <i>Lewis</i>	Last <i>Davis</i>	4. DATE OF DEATH <i>November 6 1959</i>
S. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>9/22/1883</i>	9. AGE (In years last birthday) yrs. <i>76</i>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>	
13. FATHER'S NAME <i>Thomas Walker Lewis</i>		14. MOTHER'S MAIDEN NAME <i>Jane Page</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>		INFORMANT <i>Archie</i> <i>Marchis D. Davis 4402 72nd Ave., Landover</i>	
Address <i>Hills, Md.</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Lymphosarcoma</i> INTERVAL BETWEEN ONSET AND DEATH <i>200.1</i> years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO (PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a))					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) <i>4402 72nd Ave. 11/6/59</i>	
21. I certify that I attended the deceased from <i>January 1958</i> , to <i>Nov 6 1959</i> , that I last saw the deceased alive on <i>11/6/1959</i> , and that death occurred at <i>8:45 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>F. E. Musser</i> ADDRESS (Street, city or town, state) <i>Bellmeade, Md.</i> DATE SIGNED <i>11/6/59</i>					
PHYSICIAN'S NAME (Type) <i>F. E. Musser</i>					
22a. BURIAL CREMATION, REMOVAL (Specify) <i>cremation</i>		22b. DATE THEREOF <i>11/10/59</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Ft. Lincoln Crematory</i>	
22d. LOCATION (City, town, or county) <i>Pr. Geo. Co., Maryland</i>					
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Wash. D.C.</i> 24a. REC'D BY REGISTRAR <i>The S.H. Hines Co., 2901 14th St. N.W.</i> DATE <i>NOV 9 '59</i> 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>					

2251

and best coal

left carbon

left carbon

bottom

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12862

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY Prince Geo.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly	c. LENGTH OF STAY IN 1b D.O.A.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 25 East Riverdale			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital			d. STREET ADDRESS 6319 Longfellow Street		Month Day Year November 6 1959
3. NAME OF DECEASED (Type or print) David	First Robert	Middle Dennis	Lost 11-2-41	4. DATE OF DEATH 18 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 	9. AGE (In years last birthday) 18 yrs.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stock clerk		10b. KIND OF BUSINESS OR INDUSTRY Department store		11. BIRTHPLACE (State or foreign country) Dist. of Columbia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Charles Joseph Dennis		
14. MOTHER'S MAIDEN NAME Maudie F. Reh			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		
16. SOCIAL SECURITY NO. 			17. INFORMANT Charles Joseph Dennis; same address as #2.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			Address 		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 822X due to Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Automobile accident			INTERVAL BETWEEN ONSET AND DEATH 		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in an automobile that turned over.			
20c. TIME OF INJURY Month, Day, Year 10:55 a.m. 11-6-59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway	
20f. (City or town) Berwyn Heights- Pr. Geo. Md		(County) 		(State) 	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John T. Maloney			DATE SIGNED 		
EXAMINER'S NAME (Type) John T. Maloney, M.D.			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 11, 1959		22c. NAME OF CEMETERY OR CREMATORIUM Washington National	
22d. LOCATION (City, town, or county) Suitland, Md.		(State) 			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Maryland.			ADDRESS 		24a. REC'D BY REGISTRAR DATE NOV 12 '59
					24b. REGISTRAR'S SIGNATURE Arthur J. Krause

X FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V.S. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12863

Reg. Dist. No.

12929

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Prince Georges		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George County Jail			d. STREET ADDRESS 6149 Charles Way		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First ELMER	Middle CECIL	Last DUCKETT	4. DATE OF DEATH November 14, 1959	Month Day Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> Widower	8. DATE OF BIRTH April 13, 1905	9. AGE (In years from birthday) 54 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter			10b. KIND OF BUSINESS OR INDUSTRY St. Elizabeth Hosp. Hartford, Tenn.		
11. BIRTHPLACE (State or foreign country) Hartford, Tenn.			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Unknown Samuel P. Duckett			14. MOTHER'S MAIDEN NAME Unknown Mattie Clark		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. None		
17. INFORMANT Mr. Herbert G. Clark, Oxen Hill, Maryland.			Address 6149 Charles Way, Oxen Hill, Maryland.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 981X Hemorrhage and Shock DUE TO Conditions, if any, which gave rise to immediate cause (b) Gun Shot wound in Chest (c) 981X DUE TO cause lost.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot while resisting Arrest.					
20c. TIME OF INJURY Hour 9:40 p.m.		Month, Day, Year 11/14/59	20d. INJURY OCCURRED at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Jail	20f. (City or town) (County) (State) Upper Marlboro, P.G.Cty., Md.
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>James I. Boyd</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.			DATE SIGNED November 15, 1959.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Boyd		22b. DATE THEREOF 11-17-59	22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill	22d. LOCATION (City, town, or county) (State) Saintland, Md	
23. FUNERAL DIRECTOR'S SIGNATURE James I. Boyd		24a. REC'D BY REGISTRAR Wash. D.C.		24b. REGISTRAR'S SIGNATURE NOV 18 '59	
Funeral Home Address Simmons Bros. Funeral Home, 1661 Good Hope Rd., SE		DATE			

STATE OF
TEXAS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72281

72281

72281

72281

72281

72281

72281

72281

72281

72281

72281

72281

72281

72281

72281

72281

72281

72281

72281

72281

72281

72281

72281

72281

72281

72281

72281

72281

72281

72281

72281

72281

72281

72281

72281

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12864

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro		c. LENGTH OF STAY IN 1b Transient	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) In front of Fire House		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tracey's Landing	
3. NAME OF DECEASED (Type or print) EVERETT		First NICHOLAS	Middle EASTON
4. DATE OF DEATH November 5th, 1959		5. SEX Male	6. COLOR OR RACE Colored
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH June 5th, 1925	
9. AGE (In years last birthday) 34 yrs.		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer--Self-employed		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Chaneyville, Calvert Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard Henry Easton		14. MOTHER'S MAIDEN NAME Helen Mamie Young	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Richard H. Easton, Tracey's Landing, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage & shock			
981X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Gunshot wounds of chest and abdomen			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot during altercation	
20c. TIME OF INJURY Hour 9:00 p.m.		Month, Day, Year 11/5/1959	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Croome, Pr. Geo. Co., Md.	(County) (County)
(State) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>James I. Boyd</i>		DATE SIGNED 11/6/1959	
EXAMINER'S NAME (Type) James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) 11-5-59		22b. DATE THEREOF Coopers	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Dunkirk, md		22d. LOCATION (City, town, or county) Dunkirk,	
23. FUNERAL DIRECTOR'S SIGNATURE <i>P.E. Scovell, Prince Frederick, Md.</i>		24a. REC'D BY REGISTRAR NOV 17 '59	
		24b. REGISTRAR'S SIGNATURE <i>John & Anna</i>	
VS. A15ME SM 2/57			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please ~~remove~~ carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										12865				
CERTIFICATE OF DEATH										Reg. Dist. No.				
1. PLACE OF DEATH a. COUNTY Prince George					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Prince George									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly					c. LENGTH OF STAY IN lb 27 Min					b. COUNTY State, Maryland				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital					e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Chapel Oaks									
3. NAME OF DECEASED (Type or print) Lucy					First	Middle	Last	4. DATE OF DEATH Nov. 2		Month	Day	Year		
S. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 25, 1906		9. AGE (In years lost birthday) 52 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10b. KIND OF BUSINESS OR INDUSTRY None					11. BIRTHPLACE (State or foreign country) Leonardtown, Md.				
13. FATHER'S NAME Henry Hayden					14. MOTHER'S MAIDEN NAME Sophie Holley					12. CITIZEN OF WHAT COUNTRY? U. S. A.				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <small>[Yes, no, or unknown]</small> No			16. SOCIAL SECURITY NO. <small>[If yes, give war or dates of service]</small>			INFORMANT Mr. Roland Fields			Address 5208 Nye St., N. E.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: <small>IMMEDIATE CAUSE (a)</small> 442X <small>DUE TO</small> <small>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</small> (b) Pulmonary edema <small>DUE TO</small> <small>Hypertensive cardio vascular renal disease</small> (c)												<small>10 day</small>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? <small>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></small>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)												
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town)			20f. (City or town) <small>(County)</small> <small>(State)</small>					
21. I certify that I attended the deceased from Nov. 1st , 19 59 , to Nov. 2 , 19 59 , that I last saw the deceased alive on Nov. 2 , 19 59 , and that death occurred at 6:57 P.M. from the causes and on the date stated above.			ACTUAL SIGNATURE Tina Bergman			M.D. 4314 Field St. N.E. Maryland			ADDRESS (Street, city or town, state) Washington			DATE SIGNED <small>12/1/59</small>		
PHYSICIAN'S NAME (Type) Burial		22b. DATE THEREOF 11-6-59		22c. NAME OF CEMETERY OR CREMATORY Woodlawn			22d. LOCATION (City, town, or county) Washington		<small>(State)</small> D.C.					
23. FUNERAL DIRECTOR'S SIGNATURE John T. Blumenthal <small>6304 - 128th N.E.</small> <small>Washington, D.C.</small>					ADDRESS John T. Blumenthal <small>6304 - 128th N.E.</small> <small>Washington, D.C.</small>			24a. REC'D BY REGISTRAR <small>NOV 9 '59</small>		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus				

8838 -0E -PPE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12868

12931

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Dist. of Col.		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lewisdale		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. STREET ADDRESS 2517 Mozart Place		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6622 23rd Avenue						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) William Francis Fitzgerald		First	Middle	Last	4. DATE OF DEATH November 23 1959	Month	Day	Year
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 8-8-06	9. AGE (In years last birthday) 53 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer		10b. KIND OF BUSINESS OR INDUSTRY Dept. of Jus.		11. BIRTHPLACE (State or foreign country) Connecticut		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William J. Fitzgerald		14. MOTHER'S MAIDEN NAME Mary A. McGrath						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 577-54-5906		17. INFORMANT Douglas A. Clark; Warner Bldg. D.C.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary and cerebral edema INTERVAL BETWEEN ONSET AND DEATH								
434.1 DUE TO								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute congestive heart failure								
DUE TO								
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> 19. WAS AUTOPSY PERFORMED? Cause of Death. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Norwalk	(County) Connecticut	(State) Connecticut	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>John T. Maloney</i>		DATE SIGNED						
EXAMINER'S NAME (Type) John T. Maloney, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> November 23, 1959						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/25/59		22c. NAME OF CEMETERY OR CREMATORIUM St John's Cemetery		22d. LOCATION (City, town, or county) Norwalk (State) Connecticut		
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE NOV 25 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Krause		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18												Reg. Dist. No. 12867													
CERTIFICATE OF DEATH																									
1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i>				MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>				b. COUNTY <i>Prince Georges</i>													
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>				c. LENGTH OF STAY IN lb <i>15</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>W. Hyattsville, Md</i>				d. STREET ADDRESS <i>3405 Toledo Terrace</i>													
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>OR INSTITUTION</i>								e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print)		First <i>FRANK</i>		Middle		Last <i>FRIEDSON</i>		4. DATE OF DEATH <i>Dec. 25 1893</i>		Month <i>Dec</i>		Day <i>25</i>		Year <i>1959</i>											
5. SEX <i>M</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Dec. 25 1893</i>		9. AGE (In years lost birthday) <i>65</i> yrs.		IF UNDER 1 YEAR Months <i>6</i>		IF UNDER 24 HRS. Days <i>5</i>		Hours <i>0</i>											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salesman</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Rug</i>				11. BIRTHPLACE (State or foreign country) <i>Russia</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>													
13. FATHER'S NAME <i>Eliason Friedson</i>				14. MOTHER'S MAIDEN NAME <i>Sarah Diamondson</i>				INFORMANT <i>Martin Frank -4311-H ST SE Wash. D.C.</i>				Address													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>420.1</i>				17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i>				INTERVAL BETWEEN ONSET AND DEATH <i>1/2 years</i>													
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>Coronary Sclerosis</i>				(b) <i>Coronary Sclerosis</i>				(c)				PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>None</i>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH IF EITHER, NOTIFY MEDICAL EXAMINER				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) <i>Washington, D.C.</i>		(County) <i>D.C.</i>		(State) <i>D.C.</i>	
21. I certify that I attended the deceased from <i>May 14, 1959</i> to <i>Nov 14, 1959</i> that I last saw the deceased alive on <i>May 14, 1959</i> , and that death occurred <i>Nov 14, 1959</i> from the causes and on the date stated above.																ADDRESS (Street, city or town, state) <i>3055-16 21st N.W. Washington, D.C.</i>				DATE SIGNED <i>Nov 14, 1959</i>					
ACTUAL SIGNATURE <i>Dr. W. J. Hager</i>				PHYSICIAN'S NAME (Type) <i>IRWIN J. HAGER</i>				22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				22b. DATE THEREOF <i>11/27/59</i>				22c. NAME OF CEMETERY OR CREMATORIAL <i>King David Mem. Garden</i>				22d. LOCATION (City, town, or county) <i>Falls Church</i>					
23. FUNERAL DIRECTOR'S SIGNATURE <i>B. Danzansky & Sons</i>				ADDRESS <i>3501-14th ST N.W.</i>				24a. REC'D BY REGISTRAR DATE <i>NOV 30 '59</i>				24b. REGISTRAR'S SIGNATURE <i>C. E. Knapp</i>													

HAROLD STAGG 90001



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12933

CERTIFICATE OF DEATH

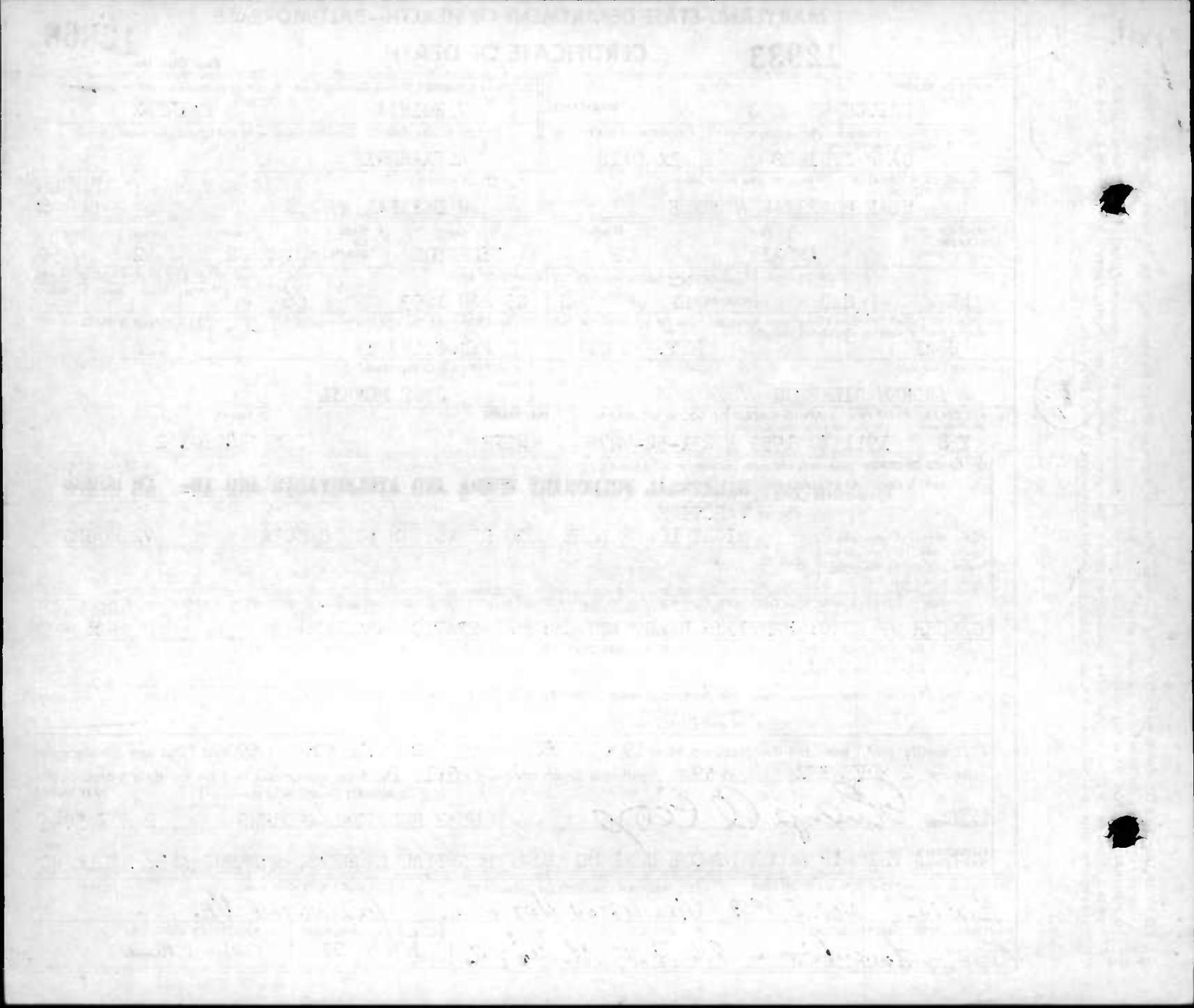
Reg. Dist. No.

12868

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE VIRGINIA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS		c. LENGTH OF STAY IN lb 14 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL ANDREWS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ADLAI		First H	Middle GILKESEN
4. DATE OF DEATH NOVEMBER 2 19 59	Month NOVEMBER	Day 2	Year 19 59
5. SEX MALE	6. COLOR OR RACE CAU	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 25 JAN 1893
9. AGE (In years last birthday) 66 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) USAF	10b. KIND OF BUSINESS OR INDUSTRY RETIRED USAF	11. BIRTHPLACE (State or foreign country) PENNSYLVANIA
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME ANDREW GILKESEN		14. MOTHER'S MAIDEN NAME JANE MCNEIL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 1911 TO 1953	INFORMANT WIFE
		Address SEE SECTION 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BILATERAL PULMONARY EDEMA AND ATELECTASIS AND IN- 163X FARTION			
DUE TO RIGHT LOWER LOBE LUNG RESECTION FOR CANCER			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) 72 HOURS			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) CANCER OF LUNG: PREVIOUS HEART ATTACK: METASTATIC CARCINOMA			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 19 OCTOBER 1959 , to 2 NOVEMBER 1959 , that I last saw the deceased alive on 2 NOVEMBER 1959 , and that death occurred at 3:15 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Philip A. Cox</i>		ADDRESS (Street, city or town, state) M.D. USAF HOSPITAL ANDREWS DATE SIGNED 2 NOV 59	
PHYSICIAN'S NAME (Type) PHILLIP A COX LT COL USAF MC USAF HOSPITAL ANDREWS, ANDREWS AFB, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF Nov. 5, 1959	22c. NAME OF CEMETERY OR CREMATORIUM ARLINGTON NATIONAL	22d. LOCATION (City, town, or county) ARLINGTON VA. (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Kirali Funeral Home</i>		ADDRESS 816 H St. N.E. Wash. DC	24a. REC'D BY REGISTRAR DATE NOV 5 '59
			24b. REGISTRAR'S SIGNATURE Arthur S. Krause



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12869

12360

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince George</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Takoma</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>17</i>	
c. LENGTH OF STAY IN 1b <i>17</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1211 Elson Place</i>		d. STREET ADDRESS <i>1211 Elson Place</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>STEVEN REICH</i>		First <i>STEVEN</i>	Middle <i>REICH</i>
4. DATE OF DEATH <i>Nov. 19</i>		Last <i>GILL</i>	Month Year Month Day Year <i>Nov. 19 59</i>
S. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 27, 1959</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>	10c. BIRTHPLACE (State or foreign country) <i>Takoma Park, Md.</i>
11. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Charles R. Gill</i>		14. MOTHER'S MAIDEN NAME <i>Rosie Stunty</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>74-12-1234</i>	
17. INFORMANT <i>Mr. Charles R. Gill, 1211 Elson Pl. Twp.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>754.7</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Frances arteriosus</i>		INTERVAL BETWEEN ONSET AND DEATH <i>life</i>	
DUE TO <i>Frances arteriosus</i>		life	
DUE TO <i>+ IV septal defect</i>		life	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>29 Sept</i> , 1959, to <i>11 Nov</i> , 1959, that I last saw the deceased alive on <i>29 Sept</i> , 1959, and that death occurred at <i>800 N. Riggs Rd.</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>800 N. Riggs Rd., W. Hyattsville, Md.</i>	
ACTUAL SIGNATURE <i>Joseph McDonald M.D.</i>		DATE SIGNED <i>1959</i>	
PHYSICIAN'S NAME (Type) <i>JOSEPH J. McDONALD M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Nov. 20, 1959</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Bethesda Cemetery</i>		22d. LOCATION (City, town, or county) <i>Prince George Co. Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Arthur Wallis, 254 Carroll St NW DC</i>		24a. REC'D BY REGISTRAR DATE <i>NOV 23 '59</i>	
ADDRESS <i>207535346</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Khan</i>	

BY DMITRIY KUZNETSOV FROM THE STATE POLYTECHNIC

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG252 11-23-59 et

12880

CERTIFICATE OF DEATH

Reg. Dist. No.

12870

1		X		TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retyped by the hospital or attending physician.									
				TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.									
X		X		Item 9 FilmG252 11-23-59 et									
077		I		12880									
2		2		12870									
MEDICAL CERTIFICATION		ACTUAL SIGNATURE		ADDRESS (Street, city or town, state)									
PHYSICIAN'S NAME (Type)		CORALIA S. FLEISCHER		DATE SIGNED Nov 18 1959									
22a. BURIAL, CREMATION OR REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)		22e. TOTAL					
Burial		11/17/59		Fort Lincoln Cemetery		Colmar Manor, Maryland							
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE							
Nalley's Funeral Home, Inc.		Mt. Rainier, Md.		NOV 18 '59		Coralia S. Fleischer							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retyped by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 9 FilmG252 11-23-59 et

12880

CERTIFICATE OF DEATH

Reg. Dist. No. 12870

1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly 56 days

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince Georges

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 16 Mt. Rainier

d. STREET ADDRESS 3815 37th St

e. IS RESIDENCE ON A FARM? YES NO

3. NAME OF DECEASED (Type or print) First John Middle T. Last Gilmore

4. DATE OF DEATH Nov 14 1959

5. SEX Male 6. COLOR OR RACE White 7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH 20 Oct. 1892

9. AGE (In years from birthday) 66 67 yrs.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired 10b. KIND OF BUSINESS OR INDUSTRY Photographer

11. BIRTHPLACE (State or foreign country) Piedmont, N.C.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME unknown

14. MOTHER'S MAIDEN NAME Louise - ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? Not 16. SOCIAL SECURITY NO. 216-10-1656

INFORMANT Florence L. Gilmore, Mt. Rainier, Md.

Address 3815-37th St., Mt. Rainier, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 518x DUE TO Pneumonia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Emphysema

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Thrombosis of portal vein with emboli of liver

19. WAS AUTOPSY PERFORMED? YES NO

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 20d. INJURY OCCURRED While at work Not while at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept. 9, 1959, to Nov. 14, 1959, that I last saw the deceased alive on Nov. 14, 1959, and that death occurred at 3:55 A.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

22a. BURIAL, CREMATION OR REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or county)

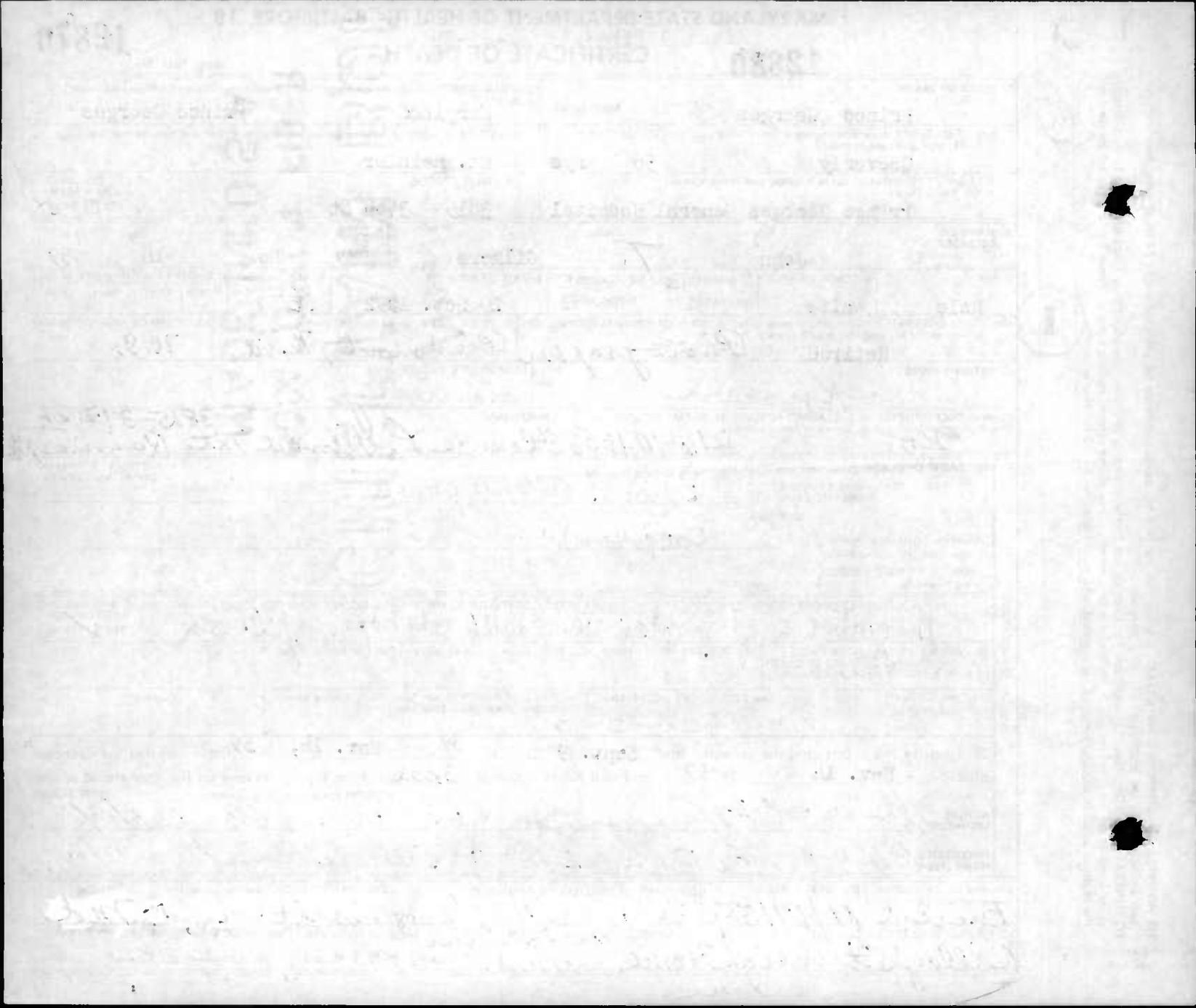
22e. TOTAL

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 Film G253 12/3/59 wk

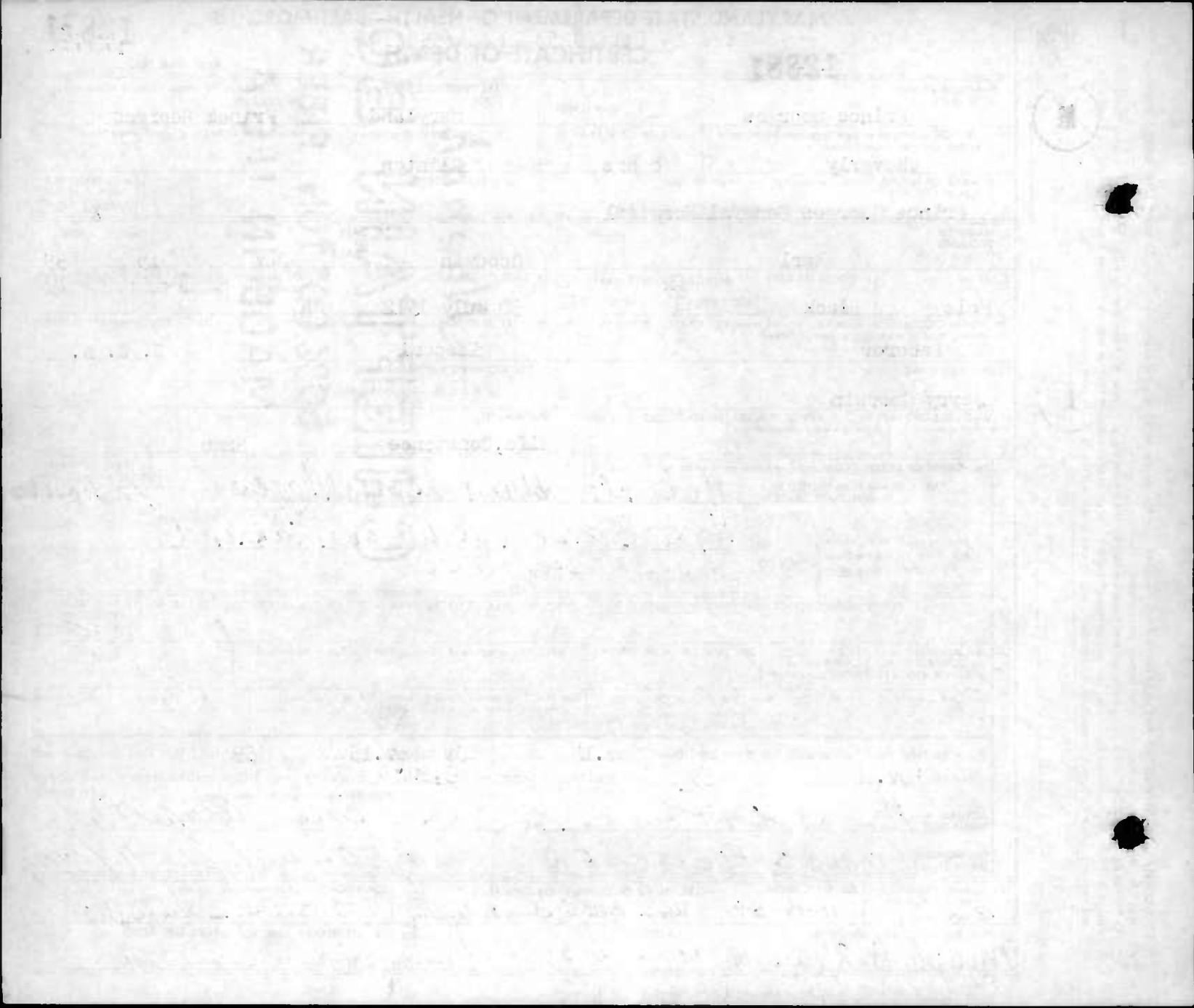
12871

12881

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 8 hrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Earl	Middle	4. DATE OF DEATH Goodwin Nov 15 1959
5. SEX Male	6. COLOR OR RACE Black	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 30 July 1912
9. AGE (In years last birthday) 47 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	11. BIRTHPLACE (State or foreign country) Missouri
		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jerry Goodwin		14. MOTHER'S MAIDEN NAME Della Bradshaw	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Wife, Constance	
17. MEDICAL CERTIFICATION		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442x Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) DUE TO (d) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 12 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 14 , 19 59 to Nov. 15 , 19 59 , that I last saw the deceased alive on Nov. 14 , 19 59 , and that death occurred at 3:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Ronald S Fleischer M.D.		ADDRESS (Street, city or town, state) 1432 Queen Anne Rd., Baltimore, Md. 21201	
PHYSICIAN'S NAME (Type) Ronald S FLEISCHER		DATE SIGNED 11/15/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-19-59	22c. NAME OF CEMETERY OR CREMATORIAL Union Bethel church Cemetery	22d. LOCATION (City, town, or county) J.B. Prince George, Md.
23. FUNERAL DIRECTOR'S SIGNATURE M Murphy & Robinson 909-6 SP 4 W Johnson Funeral Service		ADDRESS 24a. REC'D BY REGISTRAR DATE NOV 20 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12934

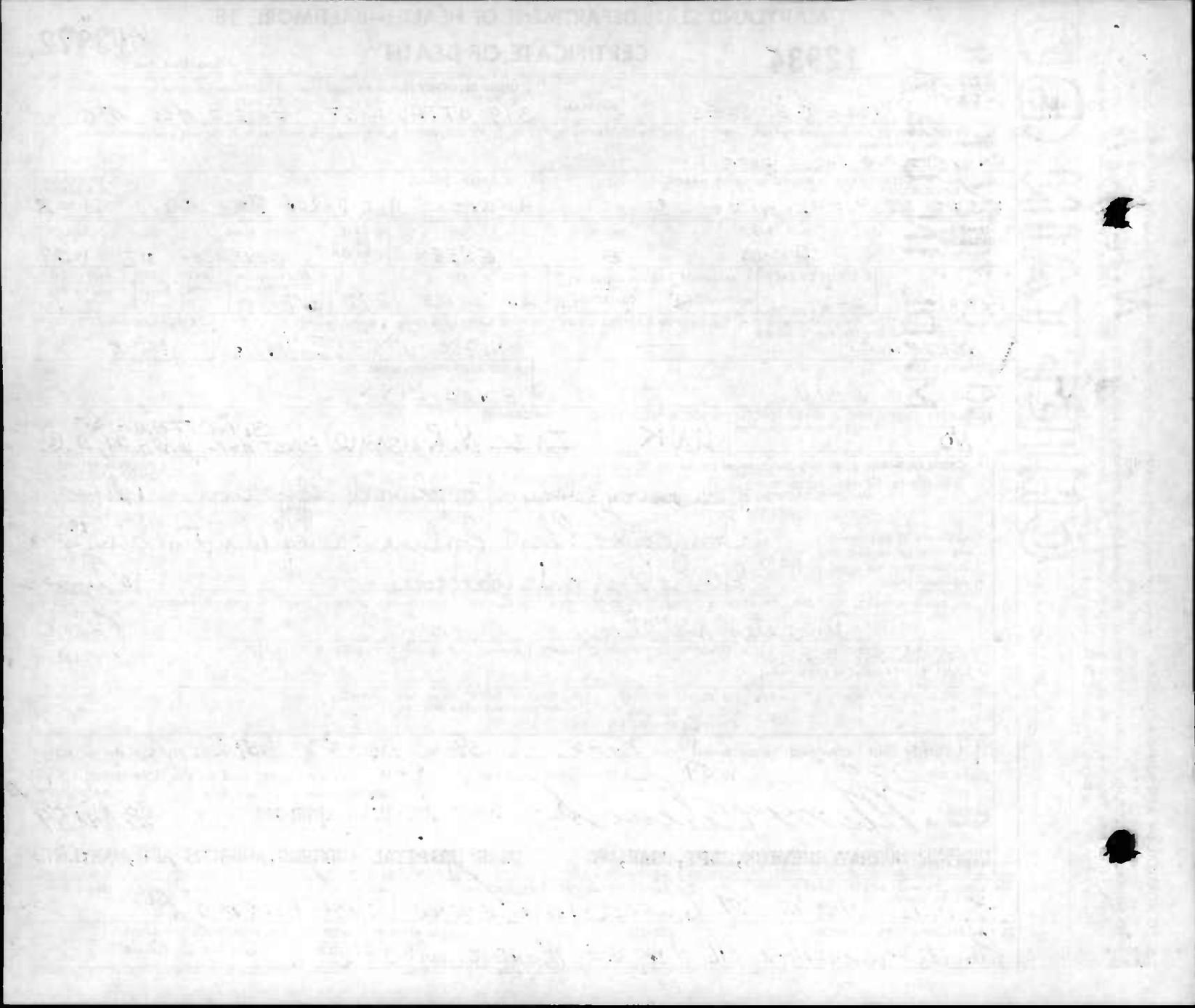
CERTIFICATE OF DEATH

Reg. Dist. No.

12872

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE 319 OTTAWA ST			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE		b. COUNTY FOREST HES. Md. P.H.			
c. LENGTH OF STAY IN 1b USAF HOSPITAL, Andrews		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Andrews AIR FORCE Base, Md.		d. STREET ADDRESS Andrews AIR FORCE Base, Md.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First ANNA	Middle E	Last GREEN		
4. DATE OF DEATH	Month November	Day 23	Year 1959		
5. SEX FEMALE	6. COLOR OR RACE CAU	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 28 JUNE 1872		
9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) MASCOUTAH, ILLINOIS	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Joseph LINN	14. MOTHER'S MAIDEN NAME EMMA LINN				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. UNK	INFORMANT INEZ N. Rousom (D)	Address 319 OTTAWA ST FOREST HES., WASH 24, D.C.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema & pleural effusion DUE TO 434.1 INTERVAL BETWEEN ONSET AND DEATH 1 hour					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive heart failure & calcified mitral ring DUE TO 10 years (c) Generalized arteriosclerosis 30 years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
MEDICAL CERTIFICATION					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Nov 23, 1959	(County) Nov 23, 1959	(State) Nov 23, 1959
21. I certify that I attended the deceased from Nov 23, 1959 , to Nov 23, 1959 , that I last saw the deceased alive on 1500 , 1959, and that death occurred at 1940 M, from the causes and on the date stated above.					
ADDRESS (Street, city or town, state) USAF HOSPITAL ANDREWS					DATE SIGNED 23 Nov 59
ACTUAL SIGNATURE <i>Murray Shevick</i>	PHYSICIAN'S NAME (Type) MURRAY SHEVICK, CAPT, USAF, MC				
PHYSICIAN'S NAME (Type) USAF HOSPITAL ANDREWS, ANDREWS AFB, MARYLAND					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF Nov. 25 1959	22c. NAME OF CEMETERY OR CREMATORIUM CONGRESSIONAL VETERANS	22d. LOCATION (City, town, or county) WASHINGTON DC.	(State) DC	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Rinaldi Funeral Home 816 H St. N.E. WASH 202</i>			ADDRESS Rinaldi Funeral Home 816 H St. N.E. WASH 202	24a. REC'D BY REGISTRAR NOV 25 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Trahan



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12873

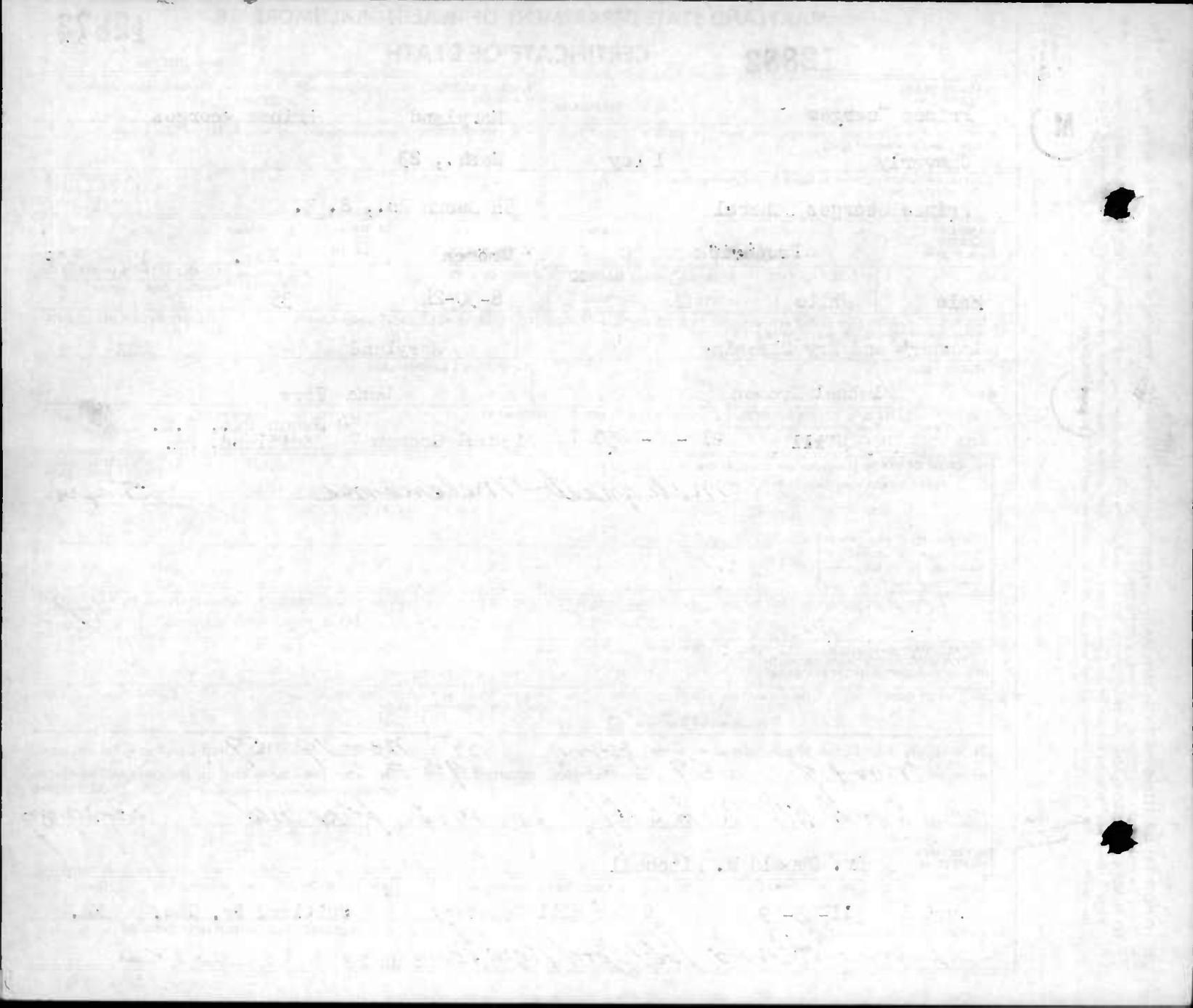
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 1 Day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Wash., 23		d. STREET ADDRESS 54 Swann Rd., S.E.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Frederick	Middle C	Last Gromen	4. DATE OF DEATH Nov. 19 1959	Month Nov.	Day 19	Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 6-30-24	9. AGE (In years last birthday) 35 yrs.	IF UNDER 1 YEAR Months 35	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundry and Dry Cleaning	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Michael Gromen	14. MOTHER'S MAIDEN NAME Lena Irre							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. WWKL 212-20-0850	INFORMANT Michael Gromen	Address 54 Swann Ad., S.E. Suitland, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) malignant melanoma 190.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary edema, carcinomatosis								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) M.D.	(County)	(State)	
21. I certify that I attended the deceased from June , 19 53 , to Nov 19 , 19 59 , that I last saw the deceased alive on Nov 19 , 19 59 , and that death occurred at 8:15 P.M. , from the causes and on the date stated above.								
ACTUAL SIGNATURE Donald W. Mitchell							ADDRESS (Street, city or town, state) 1746 1/5 Nov	DATE SIGNED Nov 23 1959
PHYSICIAN'S NAME (Type) Dr. Donald W. Mitchell								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-23-59	22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery	22d. LOCATION (City, town, or county) Suitland Pr. Geo. Md.					
23. FUNERAL DIRECTOR'S SIGNATURE Summers Bros 1661 Good Hope Rd.		ADDRESS 1661 Good Hope Rd.	24a. REC'D BY REGISTRAR Arthur S. Thomas	24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	DATE NOV 23 '59			

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12935

CERTIFICATE OF DEATH

12874

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in before being filed with the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS		c. LENGTH OF STAY IN 1b 3 HRS 20 MINS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL ANDREWS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LOTHIAN	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS CRANDELL ROAD	
3. NAME OF DECEASED (Type or print) MANUEL		First J	Middle GROPPER
4. DATE OF DEATH NOVEMBER 1 1959		Month	Day Year
5. SEX MALE	6. COLOR OR RACE CAU	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 13 DEC 1895
9. AGE (In years last birthday) 63 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GUARD	11. KIND OF BUSINESS OR INDUSTRY SMITHONIAN INSTITUTE	12. BIRTHPLACE (State or foreign country) NEW JERSEY
13. FATHER'S NAME UNKNOWN	14. MOTHER'S MAIDEN NAME UNKNOWN		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES	16. SOCIAL SECURITY NO. 1920 TO 1946	INFORMANT DAUGHTER	Address 417 50TH AVENUE CAPITOL HEIGHTS
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 12 HOURS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1 NOVEMBER, 1959, to 1 NOVEMBER, 1959, that I last saw the deceased alive on 1 NOVEMBER, 1959, and that death occurred at 11:10A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Reginald P. McManus		ADDRESS (Street, city or town, state) M.D. USAF HOSPITAL ANDREWS DATE SIGNED 1 NOV. 59	
PHYSICIAN'S NAME (Type) REGINALD P. MCMANUS CAPT USAF MC USAF HOSPITAL ANDREWS, ANDREWS AFB, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-5-59	22c. NAME OF CEMETERY OR CREMATORIAL Arlington Natl.	22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Esq. Inc. Washington D.C.	ADDRESS	24a. REC'D BY REGISTRAR DATE NOV 4 '59	24b. REGISTRAR'S SIGNATURE Catherin E. Krause

17281

RECORDED BY THE STATE OF TEXAS
HEAD TO BACK 193

2811

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12883

CERTIFICATE OF DEATH

Reg. Dist. No.

12875

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal; and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XUniversity Park		d. STREET ADDRESS 4000 College Park			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Elsie		First Elsie	Middle C	Last Hammer smith	4. DATE OF DEATH Nov 19 1959	Month Nov	Day 19	Year 1959	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH July 14 1900	9. AGE (In years lost birthday) 59 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Registered Nurse		10b. KIND OF BUSINESS OR INDUSTRY Hospital		11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME John Keller				14. MOTHER'S MAIDEN NAME Anna Kochis				Address University Park, Md.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT Mrs H J Isabell		INTERVAL BETWEEN ONSET AND DEATH 3 min			
no									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO cardiac arrest									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO asthma + elecotic heart disease									
(c) 14									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Ca of ventriles & live undercar									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Jul 14 1959, to Nov 19 1959							
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) Cumberland, Md.		(State)	
21. I certify that I attended the deceased from Jul 14 1959 , to Nov 19 1959 , that I last saw the deceased alive on Nov 19 1959 , and that death occurred at 1:45 P.M. , from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) 4514 Gallo Dr									
DATE SIGNED Hyattsville Maryland									
ACTUAL SIGNATURE Til Bergman, M.D.		M.D.							
PHYSICIAN'S NAME (Type) Dr. Til Bergman, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/23/59		22c. NAME OF CEMETERY OR CREMATORIUM St Peter & Paul Cemetery		22d. LOCATION (City, town, or county) Cumberland, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE NOV 23 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kimes			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12876

1		12884		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.		o. STATE MARYLAND		o. STATE Maryland	
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.		c. LENGTH OF STAY IN 1b RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier	
		6 Days		d. STREET ADDRESS 4213 Eastern Ave.	
		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Annie		First	Middle	Last	4. DATE OF DEATH Month Nov 17 Year 1959
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 4 July 1880	9. AGE (In years lost birthday) 79 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Austria	
13. FATHER'S NAME Harry J. Hartman		14. MOTHER'S MAIDEN NAME Hudie Graulich		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		INFORMANT	Address Mt. Rainier
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bronchopneumonia (c) Deabetes Mellitus		DUE TO Myocardial Dilaaction		INTERVAL BETWEEN ONSET AND DEATH 3 days years 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Congestive Heart Failure				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 16 , 1959, to Nov 17 , 1959, that I last saw the deceased alive on Nov 16 , 1959, and that death occurred at 1:50 A.M. , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) Benjamin S. Miller, M.D. 3824-34 1st St. Mt. Rainier	
ACTUAL SIGNATURE Benjamin S. Miller				DATE SIGNED 11/17/59	
PHYSICIAN'S NAME (Type) BENJAMIN S. MILLER					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 18, 1959		22c. NAME OF CEMETERY OR CREMATORIAL Mt. Hebron Cemetery	
				22d. LOCATION (City, town, or county) Long Island, New York	
23. FUNERAL DIRECTOR'S SIGNATURE B. Danzansky & Sons-3501 14th Street, N.W.		ADDRESS		24a. REC'D BY REGISTRAR DATE NOV 19 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MAILED 2/10/1982

SEARCHED

INDEXED

FILED

2/10/82

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12877

12936

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE	
<i>Prince George</i> MARYLAND		<i>Maryland</i> Prince Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	b. COUNTY	
<i>Cedar Hghts</i>	<i>7 yrs.</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS		
<i>912-64 6th Ave. Cedar Hghts</i>	<i>Cedar Heights</i> <i>1912 - 64" Ave.</i>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First	Middle	Last
<i>Wilbur Benjamin Harks</i>			
4. DATE OF DEATH	Month	Day	Year
		Nov.	6
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH
<i>Male</i>	<i>Negro</i>		<i>July 30, 1893</i>
9. AGE (In years less birthday) yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. Hours
<i>86</i>			
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
<i>Unknown</i>	<i>Unknown</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO.	17. INFORMANT	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)
			<i>Bilateral Pneumonia</i>
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b)	<i>241X</i>
		DUE TO	<i>Baranchial Asthma</i>
		(c)	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
<i>10-5-1959</i>	<i>19</i>	<i>1001 Eastern Ave. N.E.</i>	<i>11-6-59</i>
21. I certify that I attended the deceased from <i>10-5-1959</i> to <i>11-6-1959</i> , that I last saw the deceased alive on <i>11-5-1959</i> , and that death occurred at <i>3:50 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE	ADDRESS (Street, city or town, state)		
PHYSICIAN'S NAME (Type)	DATE SIGNED		
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM	22d. LOCATION (City, town, or county) (State)
<i>Henry S. Washington Sons</i>	<i>11-10-59</i>	<i>St. James Ch. Cemetery</i>	<i>Powhatan, Virginia</i>
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
<i>Henry S. Washington Sons</i>	<i>467 N st N.W.</i>	<i>NOV 10 '59</i>	<i>Arthur S. Kraus</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

S-350

MAY 1968

REGISTRATION

NUMBER

EXPIRY

NAME

ADDRESS

CITY

STATE

ZIP CODE

PHONE NUMBER

TELEGRAM ADDRESS

TELETYPE ADDRESS

TELEGRAPHIC ADDRESS

TELETYPE NUMBER

TELEGRAPHIC NUMBER

WISCONSIN
DEPARTMENT OF
HEALTH
AND
REHABILITATION
AGENCY
OF
THE
STATE
OF
WISCONSINREGISTRATION
NUMBEREXPIRY
DATENAME
OF
DEATH
CERTIFIER

SIGNATURE

TITLE
OR
POSITION

ADDRESS

CITY
AND
STATEZIP
CODETELEPHONE
NUMBERNAME
OF
DEATH
CERTIFIER

SIGNATURE

TITLE
OR
POSITION

ADDRESS

CITY
AND
STATEZIP
CODETELEPHONE
NUMBER

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12885

CERTIFICATE OF DEATH

Reg. Dist. No.

12878

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b 5 minutes	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eugene Leland Memorial Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 14 College Park	
f. STREET ADDRESS 6903 Dartmouth Avenue		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First FLORENCE	Middle ANNISE	Last HARRISON
4. DATE OF DEATH November 2nd,	Month	Day	Year 19 59
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH October 19th, 1889
8. AGE (In years last birthday) 70 yrs.	9. IF UNDER 1 YEAR Months	10. IF UNDER 24 HRS. Days	11. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY At home	11. BIRTHPLACE (State or foreign country) Brandon, Vermont	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME George M. Norton	14. MOTHER'S MAIDEN NAME Jennie L. Murray	Address College Park, Md.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. No	17. INFORMANT James W. Harrison, 6903 Dartmouth Ave.,	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		MYOCARDIAL INFARCTION INTERVAL BETWEEN ONSET AND DEATH 12 hrs	
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last.		DUE TO CORONARY SCLEROSIS 5 yrs	
(b) DUE TO		Hyperension/Heart Disease 6 yrs	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1953 to Nov 1959, that I last saw the deceased alive on Nov 2, 1959, and that death occurred at 5:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Benjamin S. Miller M.D.		ADDRESS (Street, city or town, state) 3824-3441T Baltimore 11-2-59	
PHYSICIAN'S NAME (Type) Benjamin S. Miller		DATE SIGNED 11-2-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 5th, 1959	
22c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Pr. Geo. Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.		ADDRESS	
		24a. REC'D BY REGISTRAR NOV 5 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ВІДЗОМЛЯЮЧІ ІЗДАВЦІ ВІД ПРОДАЖІВ СТАНДАРТІВ

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12879

12886

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryalnd	b. COUNTY Prince George
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 11 Hr		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Hyattsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				d. STREET ADDRESS 15731 29th Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					

3. NAME OF DECEASED (Type or print)	First Paul	Middle L	Last Hathaway	4. DATE OF DEATH Month Nov.	Day 2	Year 1959
--	----------------------	--------------------	-------------------------	--	-----------------	---------------------

5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 9, 1905	9. AGE (In years last birthday) 53	IF UNDER 1 YEAR Months 5	IF UNDER 24 HRS. Days 1	Hours 0	Min. 0
-----------------------	----------------------------------	---	---	--	---------------------------------------	--------------------------------------	-------------------	------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager of Bakery	10b. KIND OF BUSINESS OR INDUSTRY Safeway Stores	11. BIRTHPLACE (State or foreign country) Bennington, Kansas	12. CITIZEN OF WHAT COUNTRY? U.S.A.
---	--	--	---

13. FATHER'S NAME Dana Hathaway	14. MOTHER'S MAIDEN NAME Zura Agnes Startzman
---	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 511-07-9915	INFORMANT Paul L. Hathaway Jr.	Address 1030-Nolan Lane Chula Vista, Cal.
---	---	--	---

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		Acute myocardial infarction	
DUE TO		1 hr	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
--	--	---

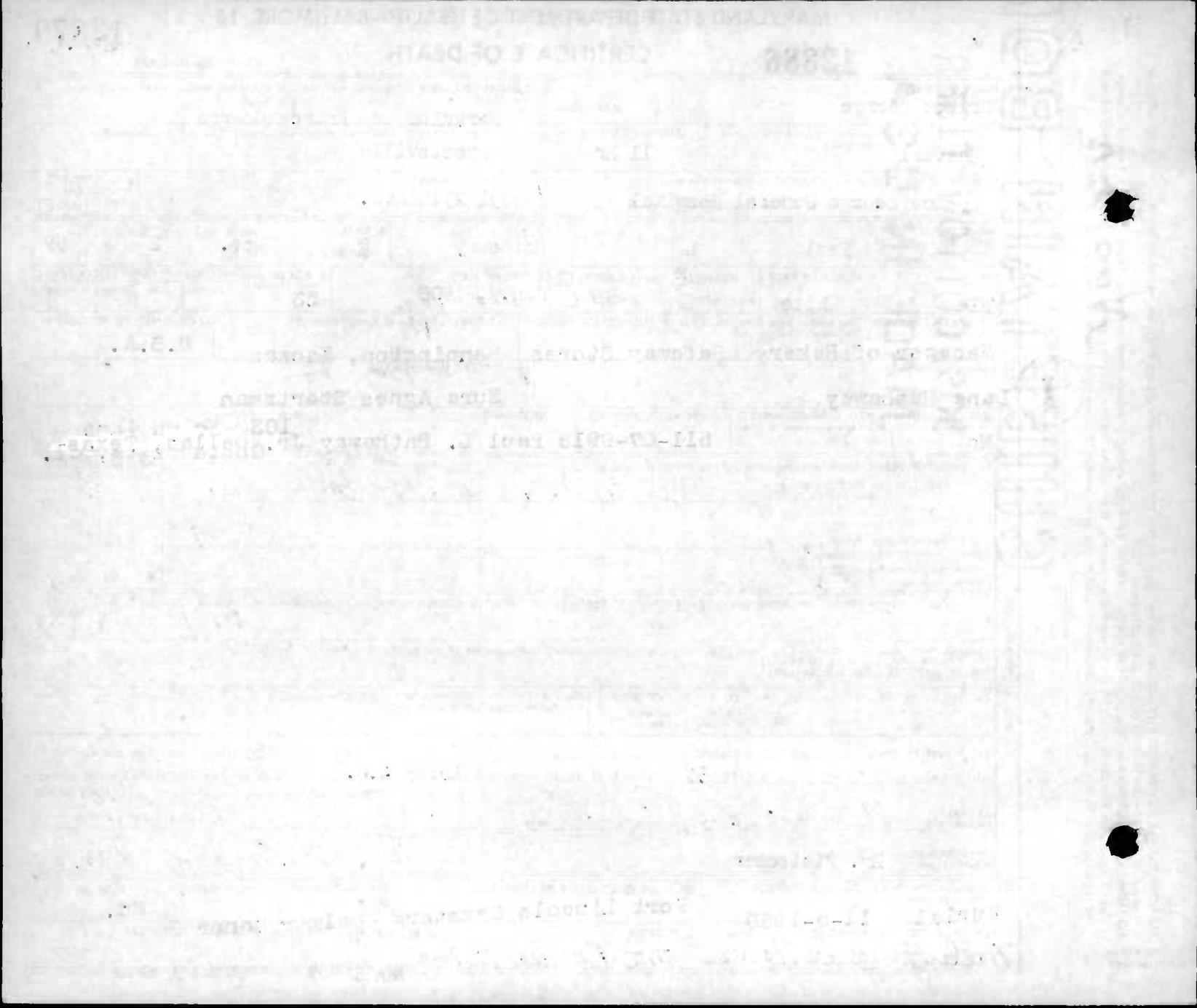
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11-1 , 19 59 , to 11-2 , 19 59 , that I last saw the deceased alive on 11-2 , 19 59 , and that death occurred at 10:55 AM from the causes and on the date stated above.			
--	--	--	--

ACTUAL SIGNATURE <i>K. Fleischer</i>	ADDRESS (Street, city or town, state) 5432 Cheever Road	DATE SIGNED 11/2/59
---	---	-------------------------------

PHYSICIAN'S NAME (Type) Dr. Fleischer	22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-5-1959	22c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Colmar Manor Md.
---	--	---------------------------------------	--	--

23. FUNERAL DIRECTOR'S SIGNATURE Nalley Funeral Home	ADDRESS Mt. Rainier Md.	24a. REC'D BY REGISTRAR NOV 5 '59	24b. REGISTRAR'S SIGNATURE Collier S. Thomas
--	-----------------------------------	---	--



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

**FOR STATE
HEALTH DEPT.**

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
1900 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12880

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb W. Lanham Hills 4 mos		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		X W. Lanham Hills	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 7730 - Garrison		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Bonnie	Middle C.	Last Hawkins	4. DATE OF DEATH Month 11	Day 7	Year 1959
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-7-59	9. AGE (In years last birthday) yrs. 3	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Roy J. Hawkins		14. MOTHER'S MAIDEN NAME Martha White		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Roy J. Hawkins, Same address		INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X DUE TO Bronchopneumonia							
Conditions, if any, which gave rise to immediate cause (b)							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 11-7-59	
EXAMINER'S NAME (Type) JOHN T. MALONEY M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 10, 1959		22c. NAME OF CEMETERY OR ORGANIZATION Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville Maryland.		24a. REC'D BY REGISTRAR DATE NOV 10 '59		24b. REGISTRAR'S SIGNATURE	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12881

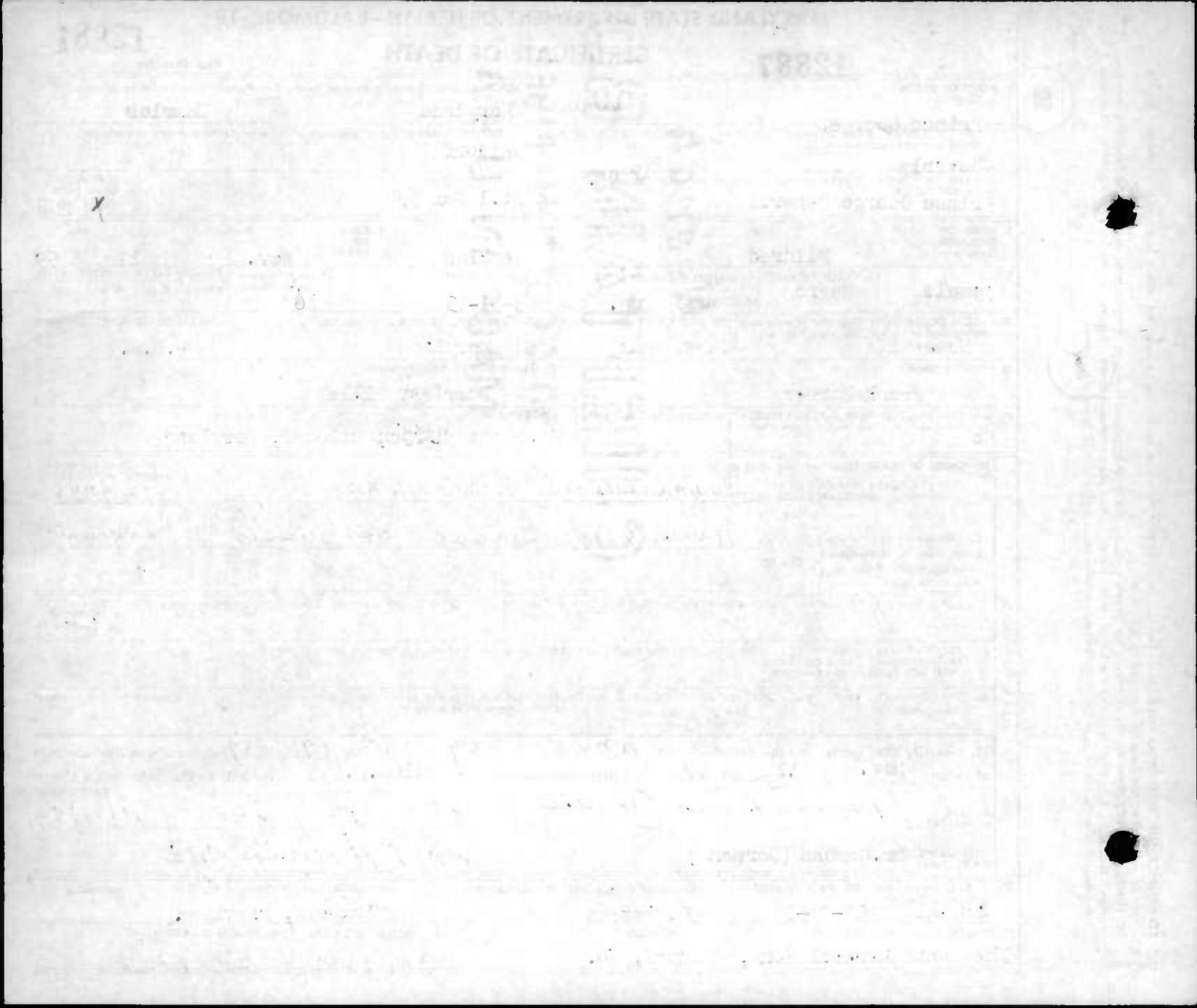
Reg. Dist. No.

12887

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician and completely filled in before the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Charles		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 12 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf		d. STREET ADDRESS Rt.1 Box 59		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Mildred		First	Middle	Last	4. DATE OF DEATH Hawkins Nov. 17 1959	Month	Day	Year
5. SEX Female		6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-31-13	9. AGE (In years last birthday) 16 yrs.	IF UNDER 1 YEAR Months 16	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Frank Harper				14. MOTHER'S MAIDEN NAME Harriett Miller				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT Harriett Harper, Waldorf, Maryland		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid hemorrhage DUE TO 452X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aneurysm Circle of Willis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH 12 days								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from Nov 5, 1959 , to Nov 17, 1959 that I last saw the deceased alive on Nov. 17, 1959 , and that death occurred at 8:20 A.M. from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>Norman D. Comeau</i> ADDRESS (Street, city or town, state) 3503 Bay St. DATE SIGNED 11/17/59								
PHYSICIAN'S NAME (Type) Dr. Comeau (Norman)								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-21-59	22c. NAME OF CEMETERY OR CREMATORIUM St Peters	22d. LOCATION (City, town, or county) Waldorf, Maryland		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Md.				ADDRESS	24a. REC'D BY REGISTRAR DATE NOV 23 '59	24b. REGISTRAR'S SIGNATURE <i>John S. Hunt</i>		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12882

12888

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Randolph md</i>		c. LENGTH OF STAY IN 1b <i>14 days</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Leland Memorial Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Marshall</i>		First <i>G.</i>	Middle <i>Henderson</i>		
4. DATE OF DEATH <i>11-18-59</i>		Last <i>18</i>	Month <i>11</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Caucasian</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-10-01</i>		
9. AGE (In years last birthday) <i>58 yrs.</i>	10. IF UNDER 1 YEAR Months <i>3</i>	11. IF UNDER 24 HRS. Days <i>1</i>	12. IF UNDER 24 HRS. Hours <i>0</i>		
13. FATHER'S NAME <i>William George Henderson</i>	14. MOTHER'S MAIDEN NAME <i>Lillian Gravera</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>(If yes, give war or dates of service)</i>	17. INFORMANT <i>Gladys Henderson</i>	Address <i>College Park, Md</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Acute Coronary Occlusion</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Arteriosclerosis</i>		Years? <i>Years?</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) <i>Diabetes</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. n. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>	20f. (City or town) <i>Baltimore</i>	(County) <i>Baltimore</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>11-8</i> , 19 <i>59</i> , to <i>11-18</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>11-18</i> , 19 <i>59</i> , and that death occurred at <i>11:22 P.M.</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Rowland E. Wilkinson</i> PHYSICIAN'S NAME (Type) <i>Rowland E. Wilkinson</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>	22b. DATE THEREOF <i>Nov 21, 1959</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Fort Lincoln Crematory</i>	22d. LOCATION (City, town, or county) <i>Colmar Manor, Md.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gasch's Sons Hyattsville Maryland.</i>			ADDRESS	24a. REC'D BY REGISTRAR DATE <i>NOV 23 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE CITY

CERTIFICATE OF DEATH

8883

Date of Birth

Date of Death
10/10/2022

Name of Deceased

REGISTRATION NO.

Cause of Death

Time of Death

Place of Death

Name of Hospital

Name of Doctor

Name of Mortician

Name of Cemetery

Name of Funeral Home

Name of Coroner

Name of Sheriff

Name of Probate Court

Name of Attorney

Name of Notary Public

Name of Clerk

Name of Sheriff

Name of Probate Court

Name of Attorney

Name of Notary Public

Name of Clerk

Name of Sheriff

Name of Probate Court

Name of Attorney

Name of Notary Public

Name of Clerk

Name of Sheriff

Name of Probate Court

Name of Attorney

Name of Notary Public

Name of Clerk

Name of Sheriff

Name of Probate Court

Name of Attorney

Name of Notary Public

Name of Clerk

Name of Sheriff

Name of Probate Court

Name of Attorney

REGISTRATION NO.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12889

CERTIFICATE OF DEATH

Reg. Dist. No.

12883

1. PLACE OF DEATH a. COUNTY Prince George		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 1 Hr. 10Min	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Elaine F.	Middle Hickey	Last 4. DATE OF DEATH November 6 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 12/25/16
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Conn.	12. CITIZEN OF WHAT COUNTRY? United States
13. FATHER'S NAME Edward D. Hickey		14. MOTHER'S MAIDEN NAME Evelyn T. Kosky	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	INFORMANT D. Hickey Edward (Father)	Address Address same as # 2
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) has since left intra cerebral extra ventricular & sub arachnoid abscess hemorrhage INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11-6 , 19 59 , to 11-6 , 19 59 , that I last saw the deceased alive on November 6 , 19 59 , and that death occurred at 9:30P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Dr. Etienne</i>	ADDRESS (Street, city or town, state) 4713 - Ballymore Rd College Park Md 11-6-59		
PHYSICIAN'S NAME (Type) Dr. Etienne	DATE SIGNED		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/10/59	22c. NAME OF CEMETERY OR CREMATORIUM Gate Of Heaven Cemetery	22d. LOCATION (City, town, or county) (State) Wheaton Maryland
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons	ADDRESS Hyattsville, Md.	24a. REC'D BY REGISTRAR DATE NOV 10 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

8221

Landmark - modernization
of the city - 1986

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be recorded by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12890

CERTIFICATE OF DEATH

12884

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 3 days		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Clyde		First D	Middle Holmes	
Last 		4. DATE OF DEATH November 1 1959	Month Day Year	
S. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/18/59	
9. AGE (In years last birthday) yrs. 		10. IF UNDER 1 YEAR Months Days Hours Min. 11	11. IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Vincent Holmes		14. MOTHER'S MAIDEN NAME Clara (nee Hamilton)		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 		
		INFORMANT Clara - Mother Address same as above.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7640 DUE TO Dehydration INTERVAL BETWEEN ONSET AND DEATH _____				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO heat. heat (c) _____				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Inter ventricula. septae defect. 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct 30 1959 to Nov 1 1959 , that I last saw the deceased alive on November 1, 1959 , and that death occurred at 10:10 AM , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) 3001 Cheverly Ave., Cheverly, Md. DATE SIGNED 11/3/59
ACTUAL SIGNATURE Bertha VanGelderan		M.D. 3001 Cheverly Ave., Cheverly, Md.		
PHYSICIAN'S NAME (Type) Bertha VanGelderan, M. D.		3001 Cheverly Aven., Cheverly, Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/3/59	22c. NAME OF CEMETERY OR CREMATORIUM Mt. Carmel Cemetery	22d. LOCATION (City, town, or county) Upper Marlboro, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Upper Marlboro, Md.		ADDRESS		24b. REC'D BY REGISTRAR NOV 4 '59
				24d. REGISTRAR'S SIGNATURE Arthur J. Greene

REF ID: A6928

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar or to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12885

Reg. Dist. No.

12891

1. PLACE OF DEATH a. COUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN lb D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale	
f. STREET ADDRESS 5411 Taylor Road		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Gregory		First Horan	Middle Horan
4. DATE OF DEATH November 25 1959	Month November	Day 25	Year 1959
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-3-53
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY School	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Horan		14. MOTHER'S MAIDEN NAME Helen Blackburn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Helen Horan; same address as # 2.	
17. INFORMANT Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Fracture of skull Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Fracture of skull DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Struck by automobile while walking home from school.	
20c. TIME OF INJURY Month, Day, Year How 3.00 a.m. 11-25-59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Riverdale
		20f. (City or town) Riverdale	(County) Pr. Geo. (State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		DATE SIGNED November 25, 1959	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) NOV. 28 1959 BURIAL		22b. DATE THEREOF NOV. 28 1959	
22c. NAME OF CEMETERY OR CREMATORIAL GATE OF HEAVEN CEM. WHEATON, MARYLAND		22d. LOCATION (City, town, or county) WHEATON, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE John Devol - 2224-Wis. Ave		ADDRESS D.C.	
24a. REC'D BY REGISTRAR NOV 30 59		24b. REGISTRAR'S SIGNATURE C. L. K. 8. K. K.	

MANUFACTURED BY - VITAMIN C FERTILIZER
MEDICAL EXAMINEE'S CERTIFICATE

1000 gm

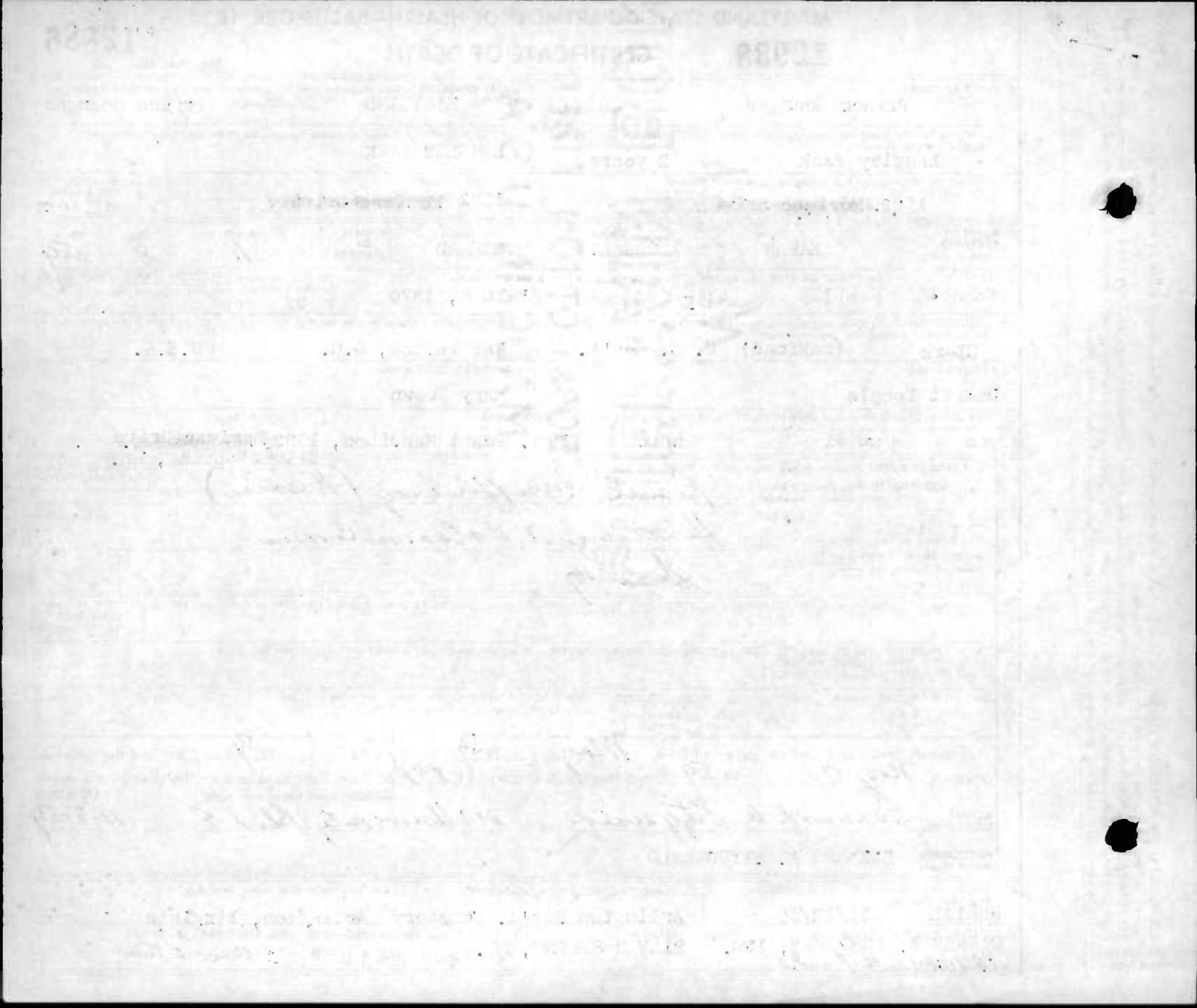
100 gm

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12938 CERTIFICATE OF DEATH

Reg. Dist. No.

12886

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Langley Park		c. LENGTH OF STAY IN 1b 2 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1302 Merimac Drive		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X LANGLEY PARK	
d. STREET ADDRESS 1302 Merimac Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First SARAH	Middle ROSALIE	Last HOWARD
S. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 9, 1870
9. AGE (In years last birthday) 89 yrs.	10. IF UNDER 1 YEAR Months 11 Days 8 Hours 59 Min.	11. IF UNDER 24 HRS. Months 11 Days 8 Hours 59 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk (retired)		10b. KIND OF BUSINESS OR INDUSTRY U. S. Gov't.	
10c. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DeWitt Tleeple		14. MOTHER'S MAIDEN NAME Mary Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. WW #1 none INFORMANT Mrs. Pearl Handiboe, 1302 Merimac Drive Address Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) DUE TO Generalized arteriosclerosis Renal insufficiency (Nephritis) Senility			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 1959, to Nov 1959, that I last saw the deceased alive on May 7, 1959, and that death occurred at 833 P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) BERNARD A. FITZGERALD		ADDRESS (Street, city or town, state) 217 University Blvd E. DATE SIGNED 11-8-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 11/12/59		22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORIAL Arlington Nat'l. Cemetery Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond J. Liska		22d. LOCATION (City, town, or county) (State) SILVER SPRING, MD. 24a. REC'D BY REGISTRAR DATE NOV 10 '59 24b. REGISTRAR'S SIGNATURE Arthur J. Krause	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12887

Reg. Dist. No.

12892

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files or to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Prince Georges MARYLAND		a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Cheverly	D.O.A.	X Mitchellville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
Prince Georges General Hospital		Woodmore Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Pearl	Middle Geneva	Last Hutchinson
4. DATE OF DEATH	Month November	Day 19	Year 1959
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Oct. 10, 1912
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Housewife		Tenent	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Maryland		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Charles Hutchinson		Mary Windsor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
No		17. INFORMANT	
		Emory R. Hutchinson; same address as # 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure INTERVAL BETWEEN ONSET AND DEATH			
434.2 DUE TO			
Conditions, if any, which gove rise to immediate cause (a), stating the underlying cause lost. (b) Cardiac asthma			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE	John J. Maloney, M.D.		DATE SIGNED
EXAMINER'S NAME (Type)	John T. Maloney, M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM	22d. LOCATION (City, town, or county) (State)
Burial	11/23/59	Ft. Lincoln Cemetery	Bladensburg, Md.
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
Ritchie Brothers	Upper Marlboro, Md.	DATE NOV 25 '59	Arthur S. Trahan

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12888

Reg. Dist. No.

12893

Items 8,9 film G252 11-23-59 et

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-trust permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH COUNTRY Prince George's		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b ½ day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pr. Geo. Gen. Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FLORINE		First JENKINS	Middle JENKINS
4. DATE OF DEATH NOV. 3 1959	Month NOV.	Day 3	Year 1959
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 19 June 1917 1911 1/48 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Va.
13. FATHER'S NAME Robert L. Wilson		14. MOTHER'S MAIDEN NAME Mamie Thomas	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT Arthur C. Jenkins (Husband) Same as # 2
Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Spontaneous intracranial hemorrhage DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral hypertension DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive cardiovascular disease			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John T. Maloney</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 4 Nov. 1959
EXAMINER'S NAME (Type) John T. Maloney M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 11-7-59	22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	22d. LOCATION (City, town, or county) Washington D.C.
23. FUNERAL DIRECTOR'S SIGNATURE S.P. Carron & Son		ADDRESS 611 K-ST. NW	24a. REC'D BY REGISTRAR NOV 12 '59
			24b. REGISTRAR'S SIGNATURE Arthur S. Trahan

MATERIALS & METHODS - DATA SOURCE
DATA EXAMINER'S CERTIFICATE

100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	1000
-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	------

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12894

CERTIFICATE OF DEATH

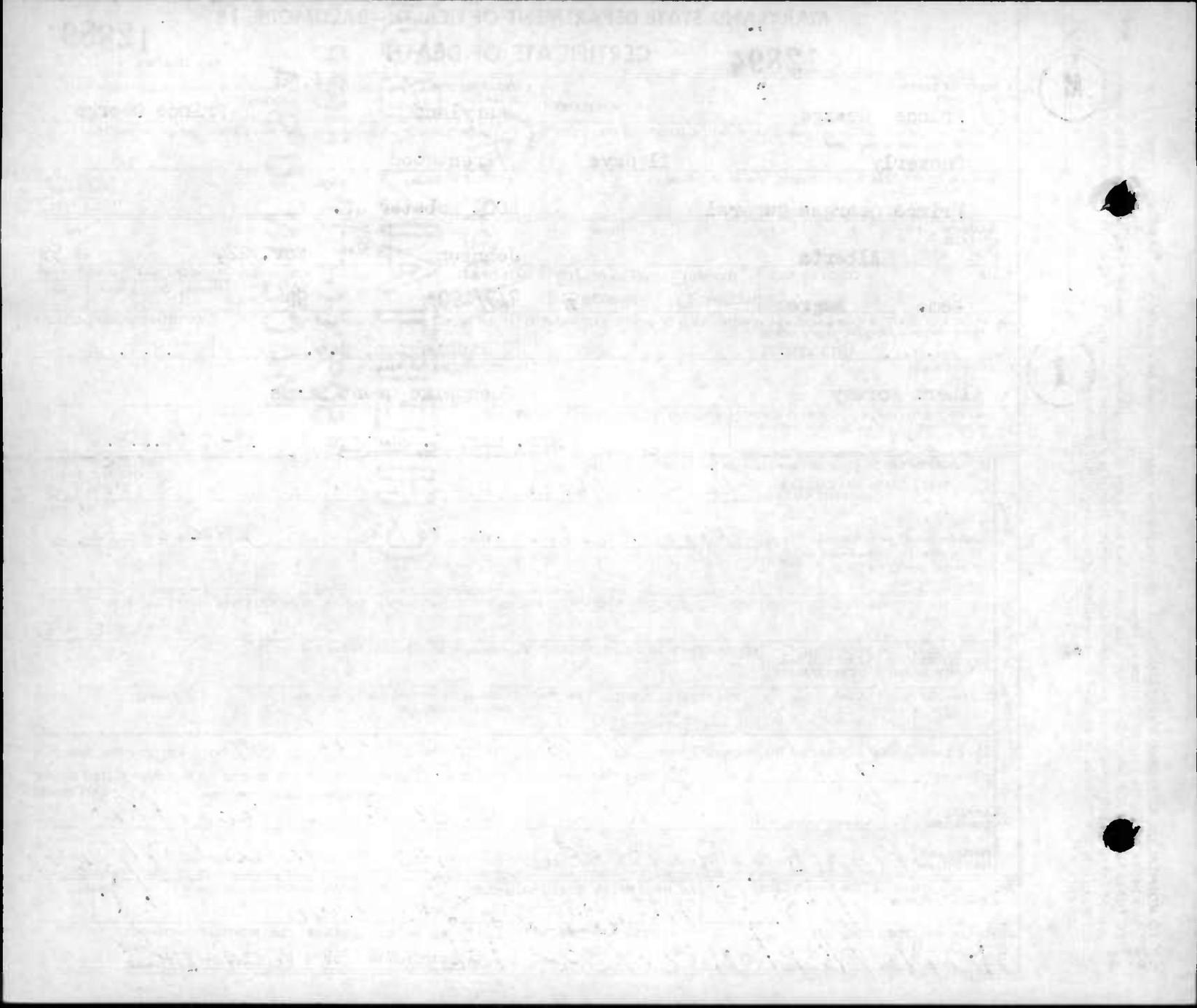
Reg. Dist. No.

12889

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 11 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brentwood		d. STREET ADDRESS 4003 Webster St.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Alberta		First	Middle	Last	4. DATE OF DEATH Johnson Nov. 22, 1959	Month	Day	Year	
S. SEX Fem.	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7/9/1909		9. AGE (In years last birthday) 50 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) G.H. I Chairman		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, d.c.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Albert Dorsey		14. MOTHER'S MAIDEN NAME Joesphine Grant Simms				Address 18-T St.N.E.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.		INFORMANT Mrs. Mary G. Spriggs		17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO Cerebro Vascular accident (c) DUE TO Hypertensive Cardio - vascular disease years		INTERVAL BETWEEN ONSET AND DEATH 10 days	
18. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 11-13 , 19 59 , to 11-22 , 19 59 , that I last saw the deceased alive on 11-21 , 19 59 , and that death occurred at 2:40 AM , from the causes and on the date stated above.									
ACTUAL SIGNATURE Ronald S. Fleischer				ADDRESS (Street, city or town, state) 1832 Queen Chapel Rd. M.D.		DATE SIGNED 11/22/59			
PHYSICIAN'S NAME (Type) Ronald S. Fleischer									
22a. BURIAL, CREMATION, REMOVAL (Specify) 11/25/59		22b. DATE THEREOF 11/25/59		22c. NAME OF CEMETERY OR CREMATORIAL Nat. Cemetery Park		22d. LOCATION (City, town, or county) Wash.			
23. FUNERAL DIRECTOR'S SIGNATURE R. N. HORTON Co. 1322 115th		ADDRESS Wash. D.C.		24a. REC'D BY REGISTRAR Arthur S. Tracy		24b. REGISTRAR'S SIGNATURE Arthur S. Tracy			
				DATE NOV 24 '59					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG252 11-23-59 et

12891

12939

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
Prince George MARYLAND		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Rural Accokeek		Accokeek, MD.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION NONE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Emma		First	Middle
		Last	Johnson
4. DATE OF DEATH		Month	Day
		11	16
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
		8. DATE OF BIRTH JULY 10 1873	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY AT Home	11. BIRTHPLACE (State or foreign country) Maryland
		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Simon		14. MOTHER'S MAIDEN NAME Gittings	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs. COLEMAN BADO
		Address 410 WESTMORELAND AVE.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334X ARTERIOSCLEROSIS DUE TO		INTERVAL BETWEEN ONSET AND DEATH 3 YRS	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CEREBROSCLEROSIS DUE TO		3 YRS	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 9-7-1957 to 11-16-1959, that I last saw the deceased alive on 11-16-1959, and that death occurred at 12:45 AM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Accokeek, MD. DATE SIGNED	
ACTUAL SIGNATURE PAUL CHEN M.D.			
PHYSICIAN'S NAME (Type) PAUL CHEN			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Nov. 19, 1959	22c. NAME OF CEMETERY OR CREMATORIUM GEORGE WASHINGTON
		22d. LOCATION (City, town, or county) Prince Geo. County, MD. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Rinaldi FUNERAL HOME 816 H St. N.E. WASH. 2, D.C.		ADDRESS	24a. REC'D BY REGISTRAR NOV 18 '59
			24b. REGISTRAR'S SIGNATURE Arthur S. Khan

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

0000

Date of Birth

Name of Deceased

Name of Hospital

Address of Hospital

City of Hospital

State or Province

Zip Code

Phone No.

Date of Death

Age at Death

Cause of Death

Time of Death

Place of Death

Signature

Title

Address

City

State

Zip

Phone

Signature

Title

Address

City

State

Zip

Phone

Signature

Title

Address

City

State

Zip

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12854 CERTIFICATE OF DEATH

Reg. Dist. No.

12891

1. PLACE OF DEATH a. COUNTY <i>N. George.</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Washington D.C.</i>		b. COUNTY <i>Fence St.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville.</i>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>		d. STREET ADDRESS <i>2708-30th St. S.E.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Print Branch Nursing Home</i>				d. STREET ADDRESS <i>2708-30th St. S.E.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) IZOLA B		First	Middle	Last	KENNEDY	Month	Day	Year	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-18-87</i>		9. AGE (In years lost birthday) <i>72 yrs.</i>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>At home</i>		11. BIRTHPLACE (State or foreign country) <i>Georgia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Ralph Kennedy 2708-30th St. S.E.</i>		Address			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>450.0</i>		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>General Visceral Failure</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 months</i>					
(c) <i>Generalized Arteriosclerosis</i>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <i>Arteriosclerotic Heart Disease, Diabetes, Rheum. Arthritis</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>-</i>							
20c. TIME OF INJURY Hour a. m. p. m.	Month —	Day 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	20f. (City or town) —	(County)	(State)		
21. I certify that I attended the deceased from <i>10/14</i> , 19 <i>58</i> , to <i>11/24</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>11/22</i> , 19 <i>59</i> , and that death occurred at <i>6:15 P.M.</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Frank M. Trozzo, Jr.</i>		M.D. <i>3501 Hamilton St</i>		ADDRESS (Street, city or town, state) <i>Hyattsville Md</i>		DATE SIGNED <i>11/24/59.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11-28-59</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>St. Lincoln Cem.</i>		22d. LOCATION (City, town, or county) <i>Bladensburg Md.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>W.W. Chambers Co.</i>		ADDRESS <i>517-11th St. S.E. Washington D.C.</i>		24a. REC'D BY REGISTRAR DATE <i>NOV 30 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12892

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forestville d. STREET ADDRESS 6600 D'Aroy Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital						
3. NAME OF DECEASED (Type or print) First HERMAN Middle C. Surname KLEIN		4. DATE OF DEATH Month November Day 5th, Year 19 59				
5. SEX Male	6. COLOR OR RACE White	7. JEWISH NEVER MARRIED <input checked="" type="checkbox"/> b. DATE OF BIRTH Jan. 15th, 1895	9. AGE (In years from birthday) 64 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Cemetery	11. BIRTHPLACE (State or foreign country) New York			
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) WWI 1918-1919		16. SOCIAL SECURITY NO. 577-16-2806A 17. INFORMANT William W. Edmunds, 5231 St. Barnabas Rd. S.E. Address Wash. 21, D.C.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute congestive heart failure 442 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardio vascular renal disease DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <i>James I. Boyd</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 11/6/1959			
EXAMINER'S NAME (Type) James I. Boyd	22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/10/1959	22c. NAME OF CEMETERY OR CREMATORIUM Lincoln Memorial Cemetery	22d. LOCATION (City, town, or county) Suitland Rd. Pr. Geo. Co., Md.	(State)
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.	ADDRESS		24a. REC'D BY REGISTRAR DATE NOV 10 '59		24b. REGISTRAR'S SIGNATURE <i>C. Louis S. Kraus</i>	

8-1-1979年7月1日付の「昭和54年農林省農業試験場規則」(昭和54年農林省令第10号)の規定による。

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G252 11-27-59 et

12893

12896

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville P.O.	
3. NAME OF DECEASED (Type or print) Joseph		First William	Middle Kreamer
Last 		4. DATE OF DEATH Nov 18	Month Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7 Feb 1907
9. AGE (In years last birthday) 83 1/2 yrs.		10. IF UNDER 1 YEAR Months 83 1/2 yrs.	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker		10b. KIND OF BUSINESS OR INDUSTRY Bakery	11. BIRTHPLACE (State or foreign country) Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Charles Kreamer		14. MOTHER'S MAIDEN NAME Daisy Mary Dove	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None 577-10-8365	
17. INFORMANT Margaret A. Kreamer, 5321 Greenway Drive		Address Hyattsville P.O. Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), or (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brachopneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Malnutrition, metabolic acidosis And (b) Eosphagospasm, Chronic Due to 491X Due to 2 days Due to 2 wks Due to 1 yr.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) Bladensburg, Maryland	
21. I certify that I attended the deceased from September 19, 1959 to Nov. 18, 1959 that I last saw the deceased alive on Nov 18, 1959 , and that death occurred at 6:00A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE William D. Resson M.D.		ADDRESS (Street, city or town, state) 5304 Anacostia Road DATE SIGNED 11/18/59	
PHYSICIAN'S NAME (Type) Dr. William Resson, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/21/1959	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) Washington, D.C. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.		ADDRESS	
		24a. REC'D BY REGISTRAR DATE NOV 23 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Haas	

—
—
—

7039-8 1974

• 4 • *Journal*

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12894

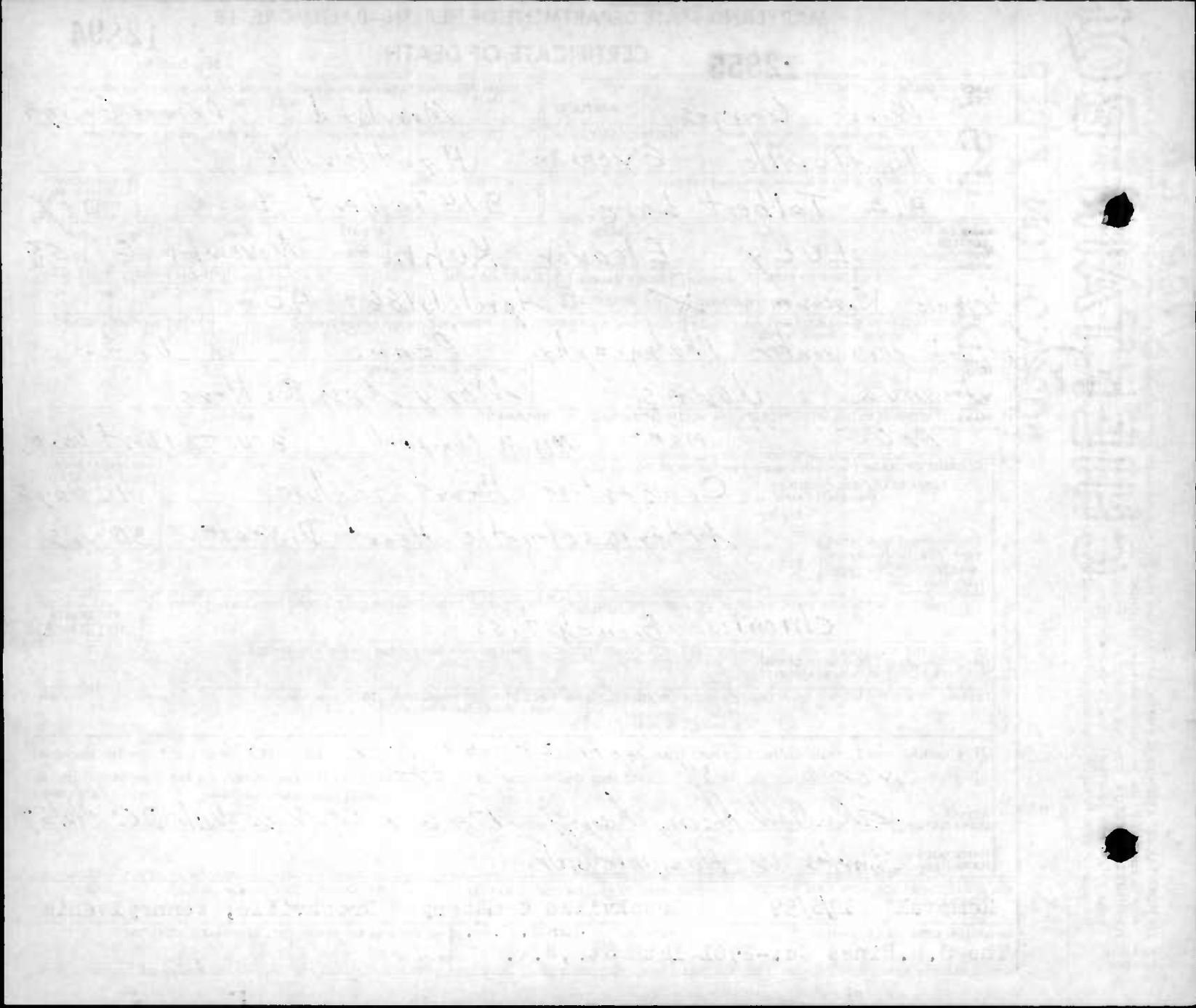
12855

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince Georges, Maryland</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Haytsville</i>	c. LENGTH OF STAY IN 1b <i>6 years</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>15 Haytsville,</i>	d. STREET ADDRESS <i>1814 Talbert Lane</i>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>814 Talbert Lane.</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Lucy Eleanor Kuhn.</i>	First <i>Lucy</i>	Middle <i>Eleanor</i>	Last <i>Kuhn.</i>
4. DATE OF DEATH <i>November 6 1959</i>	Month <i>November</i>	Day <i>6</i>	Year <i>1959</i>
5. SEX <i>female</i>	6. COLOR OR RACE <i>Caucasian</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 1, 1869</i>
9. AGE (In years last birthday) <i>90 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>retired photographer</i>	11. KIND OF BUSINESS OR INDUSTRY <i>Photography</i>	12. BIRTHPLACE (State or foreign country) <i>Penn.</i>
13. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	14. FATHER'S NAME <i>Joshua Jones.</i>	15. MOTHER'S MAIDEN NAME <i>Mary Ann Bullers.</i>	
16. SOCIAL SECURITY NO. <i>None.</i>	17. INFORMANT <i>Mrs. M. Campbell.</i>	18. ADDRESS <i>814 Talbert Lane,</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <i>Congestive Heart failure.</i> (c) DUE TO <i>Arteriosclerotic Heart Disease.</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>chronic Bronchitis.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>10 days.</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Sept. 28, 1959</i> to <i>Nov. 6, 1959</i> that I last saw the deceased alive on <i>Nov 6, 1959</i> , and that death occurred at <i>8:30 P.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>1746 K St. N.W. Wash. D.C.</i> DATE SIGNED <i>11/6/59</i>	
ACTUAL SIGNATURE <i>Charles W. Humphreys, Jr.</i>	PHYSICIAN'S NAME (Type) <i>Charles W. Humphreys, Jr.</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	22b. DATE THEREOF <i>11/8/59</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Brookville Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Brookville, Pennsylvania</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>The S.H. Hines Co. - 2901 14th St., N.W.</i>	ADDRESS <i>Wash. D.C.</i>	24a. REC'D BY REGISTRAR DATE <i>NOV 9 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Charles S. Hines</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please report carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 12896

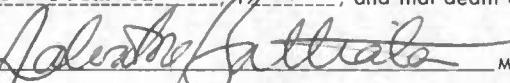
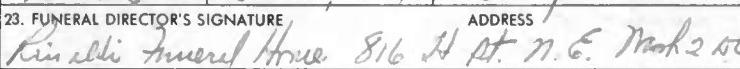
12940		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE DISTRICT OF COLUMBIA	
1. PLACE OF DEATH o. COUNTY PRINCE GEORGES MARYLAND		c. LENGTH OF STAY IN 1b 3 DAYS	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON, D.C. 47 X - 3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL ANDREWS AFB WASH 25, D.C.		d. STREET ADDRESS 14 DANBURY STREET, S.W.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First DANIEL Middle GLENN Last LEMASTER		4. DATE OF DEATH NOVEMBER 25 1959	
5. SEX MALE		6. COLOR OR RACE CAU	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 22 NOV 1959	
9. AGE (In years lost birthday) yrs. 3		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE	
10b. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JAMES A. LEMASTER		14. MOTHER'S MAIDEN NAME ALICE KISER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. N/A	
17. INFORMANT HOSPITAL CHART		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 763.0		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO undetermined	
(c)		DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) 1135A M	
21. I certify that I attended the deceased from 22 November, 1959, to 25 November, 1959, that I last saw the deceased alive on 25 November 1959, and that death occurred at 1135A M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE 		M.D. USAF HOSP ANDREWS AFB WASH 25, D.C.	
PHYSICIAN'S NAME (Type) SALVATORE BATTISTA CAPT USAF MC		USAF HOSP ANDREWS AFB WASH 25, D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 30, 1959	
22c. NAME OF CEMETERY OR CREMATORIAL Celington Nat. Cemetery		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE 		ADDRESS 816 N. St. N.E. Wash 25C.	
24a. REC'D BY REGISTRAR NOV 30 '59		24b. REGISTRAR'S SIGNATURE 	

TABLE 1A12-01

(Wet weight)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12897

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH

o. COUNTY

Prince Georges

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cheverly

c. LENGTH OF STAY IN lb

2 days

d. NAME OF HOSPITAL (If not in hospital, give street address)

OR INSTITUTION

Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)

o. STATE Maryland

b. COUNTY Prince Georges

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

41 Laurel

d. STREET ADDRESS

336 Laurel Ave.

e. IS RESIDENCE
ON A FARM?YES NO 3. NAME OF
DECEASED
(Type or print)First
MargaretMiddle
LLast
Lowery4. DATE
OF
DEATHMonth
Nov.Day
8Year
59

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

10 Sept. 1886

9. AGE (In years
last birthday)

73 yrs.

10. IF UNDER 1 YEAR

Months
Days

11. IF UNDER 24 HRS.

Hours
Min.10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Sylvester Emerick

14. MOTHER'S MAIDEN NAME

Jeanette Speelman

Address

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
(If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

INFORMANT

Wren L Jones, Laurel Md

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

420.1

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.
(b)

DUE TO

(c)

Coronary Thrombosis

INTERVAL BETWEEN
ONSET AND DEATH

48 hrs

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

19. WAS AUTOPSY
PERFORMED?
YES NO 20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19 p. m.20d. INJURY OCCURRED
While Not while
at work at work 20e. PLACE OF INJURY (Name, form,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from 6 Nov. 1959, to 8 Nov. 59, that I lost sow the deceased
alive on 8 Nov. 1959, and that death occurred at 12,30A.M. from the causes and on the date stated above.ACTUAL
SIGNATURE

Norman Comeau

ADDRESS (Street, city or town, state)

DATE SIGNED

3503 Perry St.

11/8/59

PHYSICIAN'S
NAME (Type)

Dr. Norman Comeau, M.D.

Mt. Rainier, Md

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial 11/8/59 Fort Lincoln Cem.

22d. LOCATION (City, town, or county)

(State)

Colony Manor Md

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

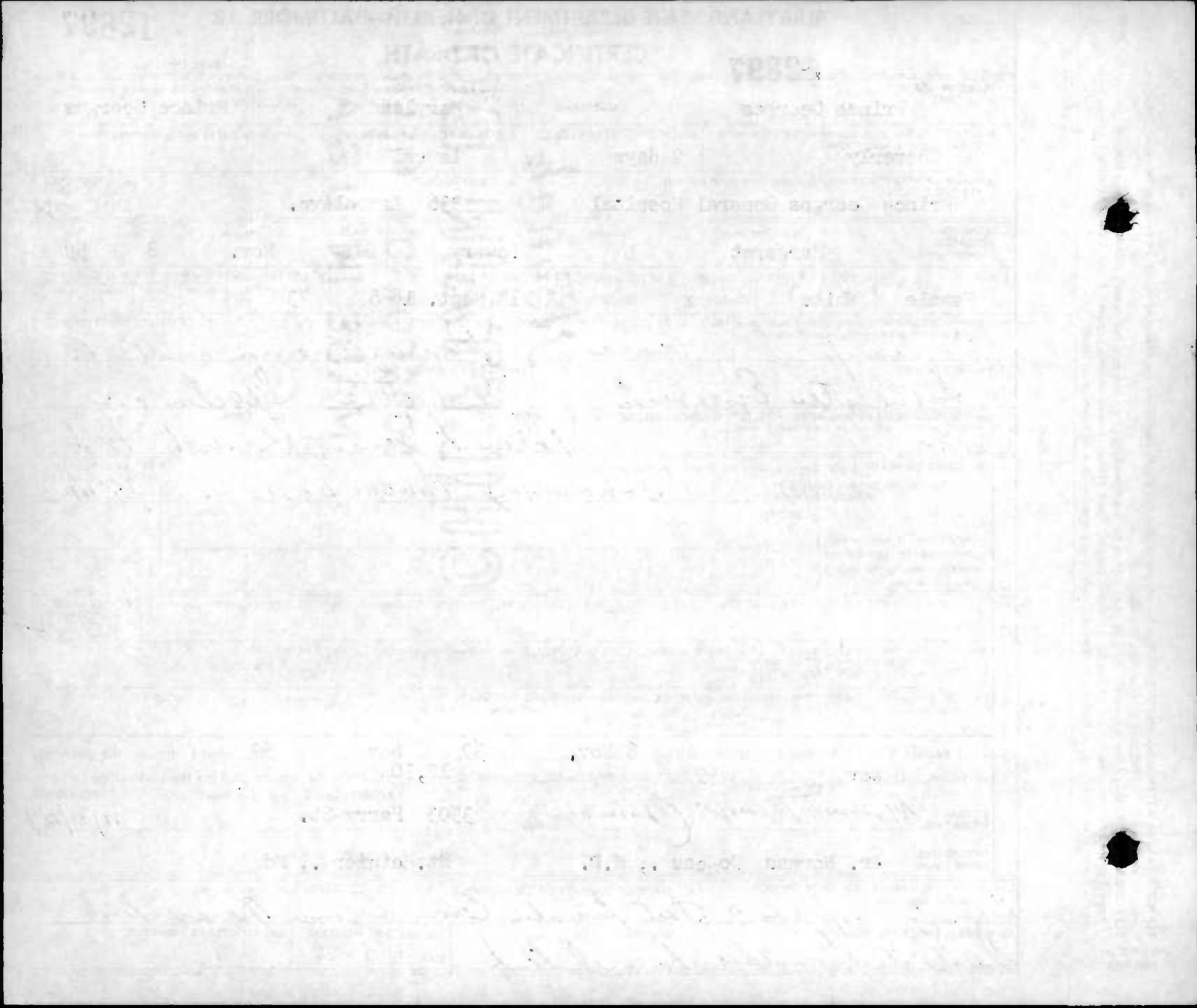
De Witt McDonald, Laurel, Md

24a. REC'D BY REGISTRAR

DATE NOV 13 '59

24b. REGISTRAR'S SIGNATURE

Catherine E. French



1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

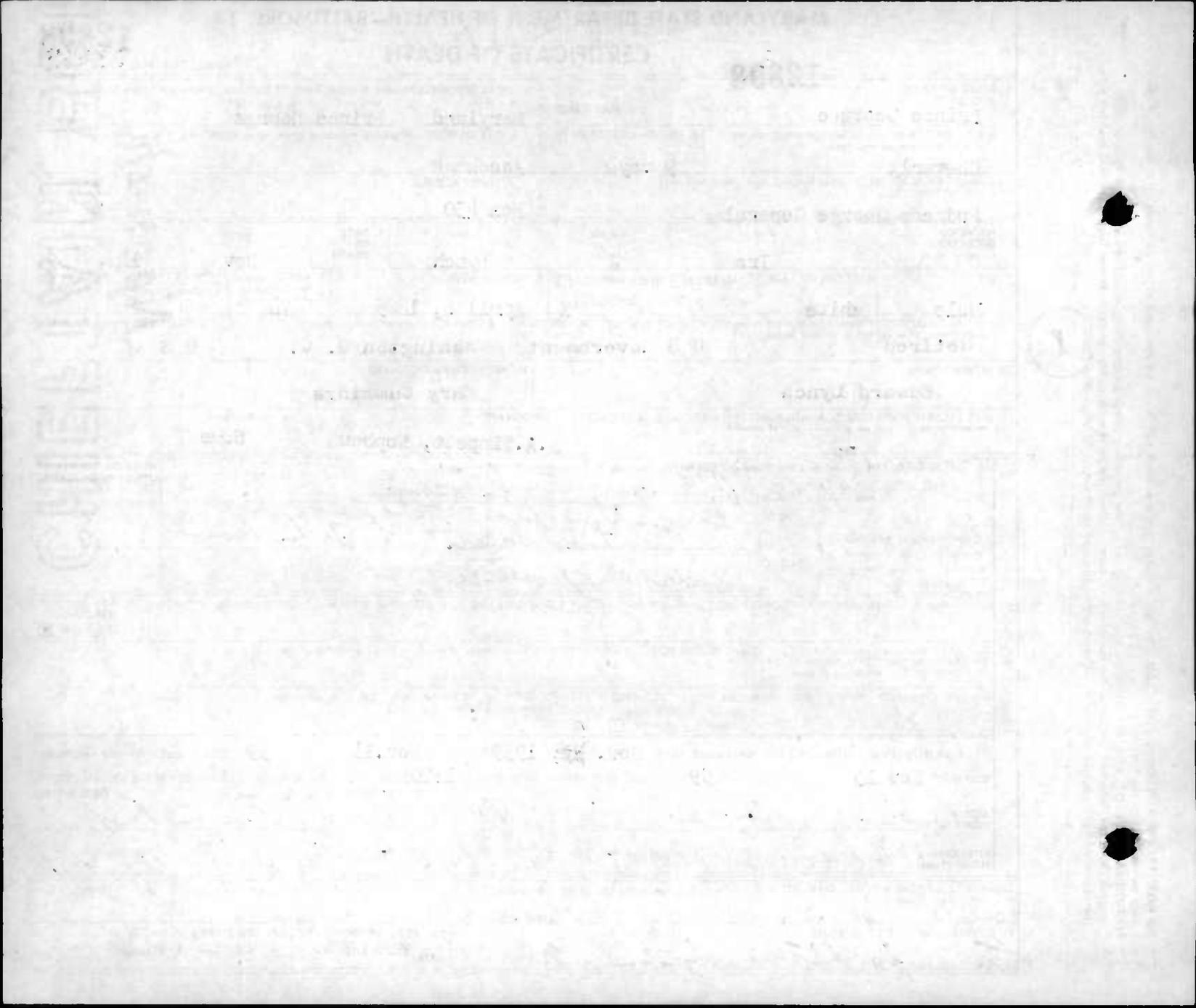
Items 22, Film G252 11/19/59 iwk

12898

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Prince George				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 9 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Accokeek		d. STREET ADDRESS Box 430				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Ira J. Lynch		First	Middle	Last	4. DATE OF DEATH Nov 14, 1959	Month	Day	Year		
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH April 6, 1885		9. AGE (In years lost birthday) 74 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY U S Government		11. BIRTHPLACE (State or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? U S A				
13. FATHER'S NAME Edward Lynch				14. MOTHER'S MAIDEN NAME Mary Cummings						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT A.A.Tippett, Nephew,		Address Same				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism DUE TO Congestive Heart Failure INTERVAL BETWEEN ONSET AND DEATH										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic heart disease (c) enlarged prostate										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 5		20f. (City or town) Bladensburg, Md.		(County) Prince George Co.	(State) Md.	
21. I certify that I attended the deceased from Nov. 14, 1959 , to Nov. 14, 1959 , that I last saw the deceased alive on Nov. 13, 1959 , and that death occurred at 1:20 P.M. from the causes and on the date stated above.										
ADDRESS (Street, city or town, state) 1432 Queen Anne Rd. DATE SIGNED 11/18/59										
ACTUAL SIGNATURE Ronald Fleischer M.D.										
PHYSICIAN'S NAME (Type) RONALD S. FLEISCHER Hyattsville 11/18/59										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 17, 1959		22c. NAME OF CEMETERY OR CREMATORIUM Evergreen Cemetery		22d. LOCATION (City, town, or county) Bladensburg, Md.		(State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Francis Lynch's Sons, Hyattsville, Md.		ADDRESS				24a. REC'D BY REGISTRAR NOV 17 '59	24b. REGISTRAR'S SIGNATURE Arthur & Francis			



1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12899

CERTIFICATE OF DEATH

Reg. Dist. No.

12899															
1. PLACE OF DEATH a. COUNTY Prince Georges				MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland				b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN lb 1 Day				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 16 Mt. Rainier				d. STREET ADDRESS 3713 34th St.,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General								e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First Edward	Middle Franklin	Last Malay	4. DATE OF DEATH 11-19-59		Month 11	Day 19	Year 59						
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 4-6-05		9. AGE (In years last birthday) 54 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		10b. KIND OF BUSINESS OR INDUSTRY Washington Post Gloucester Co. Va		11. BIRTHPLACE (State or foreign country) U.S.		
13. FATHER'S NAME Alexander J. Malay		14. MOTHER'S MAIDEN NAME Virgil Mary Gwynn		12. CITIZEN OF WHAT COUNTRY? Gloucester Va.											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 2-28-03-4128		17. INFORMANT Daughter		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 490X		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
MEDICAL CERTIFICATION										DUE TO Shock		INTERVAL BETWEEN ONSET AND DEATH			
														Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Multiple pulmonary infections, right lung	
								DUE TO Lobate pneumonia (left upper lobe)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Multiple pulmonary infections, right lung		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) Colmar Manor, Md. (State) Md.					
21. I certify that I attended the deceased from Apr. 17, 1959 , to Nov. 19, 1959 , that I last saw the deceased alive on Nov. 19, 1959 , and that death occurred at 8:02 AM , from the causes and on the date stated above. ACTUAL SIGNATURE Charles C. Hageage M.D. 3308 Perry St., Mt. Rainier, Md. ADDRESS (Street, city or town, state) 11/20/59 DATE SIGNED															
PHYSICIAN'S NAME (Type) Dr. Charles Hageage															
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/23/59		22c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln		22d. LOCATION (City, town, or county) Colmar Manor, Md. (State) Md.									
23. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home Mt. Rainier, Inc.		ADDRESS md.		24a. REC'D BY REGISTRAR DATE NOV 23 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus									

CHARTERED

00201

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12941

CERTIFICATE OF DEATH

Reg. Dist. No.

12960

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		PRINCE GEORGE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE Maryland COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b 10 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chillum, Hyattsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 722 Rittenhouse Street		d. STREET ADDRESS 722 - Rittenhouse street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) NICOLA		First VICTOR	Middle MANGO	4. DATE OF DEATH Nov. 29 1959	Month Day Year
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 10, 1879	9. AGE (In years last birthday) 80 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clothes Designer		10b. KIND OF BUSINESS OR INDUSTRY Clothing		11. BIRTHPLACE (State or foreign country) Italy	
13. FATHER'S NAME Anthony Mango		14. MOTHER'S MAIDEN NAME Concetta Salerno		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 142-05-1395		17. INFORMANT Pasqualine Mongo 722 Rittenhouse St. Chillum, MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) GENERALIZED ARTERIOSCLEROSIS 10 years				INTERVAL BETWEEN ONSET AND DEATH 10 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) DIABETES MELLITUS				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from APRIL 1957, to NOV. 29, 1959, that I last saw the deceased alive on NOV. 28, 1959, and that death occurred at 9:05 A.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) M.D. 6216 NTH Ave NE Washington DC	
ACTUAL SIGNATURE William F. Simpson Jr.				DATE SIGNED	
PHYSICIAN'S NAME (Type) William F. Simpson Jr.					
22a. BURIAL, CREMATION, REMOVAL* (Specify) Burial		22b. DATE THEREOF 12/2/59		22c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln	
22d. LOCATION (City, town, or county) Cooper Manor, Md				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home		ADDRESS Mt. Rainier Md.		24a. REC'D BY REGISTRAR DATE DEC 2 '59	
				24b. REGISTRAR'S SIGNATURE Orville S. Kline	

MANUFACTURED STATE INSURANCE DEPARTMENT OF HEALTH - CALIFORNIA 19

CERTIFICATE OF DEATH

CEMETERY

DANIEL

1X-3

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files or to burial, cremation, or removal.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										12901	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)						
<i>Trunc George</i> MARYLAND					a. STATE Maryland					b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Oakland</i>					c. LENGTH OF STAY IN 1b <i>26 years</i>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Oakland</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>6512 - Marlboro Rd. N.E.</i>					d. STREET ADDRESS <i>16512 - Marlboro Rd. N.E.</i>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <i>Nellie</i>	Middle <i>Elizabeth</i>	Haske Lost <i>May 1959</i>	4. DATE OF DEATH <i>Nov. 9 1959</i>	Month	Day	Year			
5. SEX		6. COLOR OR RACE <i>Female White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 20, 1886</i>	9. AGE (In years, months, birthday) <i>73 yrs.</i>	IF UNDER 1 YEAR <i>Months</i>	IF UNDER 24 HRS. <i>Days</i>	Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Candy Store</i>			11. BIRTHPLACE (State or foreign country) <i>Washington D.C.</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Joseph Baird</i>			14. MOTHER'S MAIDEN NAME <i>Elizabeth Pfeffer</i>			Address <i>14212 London St.</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown) <i>No</i>			16. SOCIAL SECURITY NO.			17. INFORMANT <i>None Magdalene Robinson, Seine Ising</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>442x</i> DUE TO <i>Congestive heart failure</i>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Diabetes</i> DUE TO <i>cardiovascular renal disease</i>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Diabetes</i>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour a. m. p. m.			Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Washington, D.C.</i>		(County) <i>D.C.</i>	(State) <i>D.C.</i>		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .										DATE SIGNED <i>Nov. 9, 1959</i>	
ACTUAL SIGNATURE <i>James I. Boyd</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>									
EXAMINER'S NAME (Type) <i>James I. Boyd</i>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11-12-59</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>St. Mary's</i>		22d. LOCATION (City, town, or county) <i>Washington, D.C.</i>		(State) <i>D.C.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>W.W. Chambers Co Inc., Washington, D.C.</i>		ADDRESS <i>W.W. Chambers Co Inc., Washington, D.C.</i>		24a. REC'D BY REGISTRAR <i>C. Arthur & Kraus</i>		24b. REGISTRAR'S SIGNATURE <i>C. Arthur & Kraus</i>		DATE NOV 16 '59			

most each supposed
insects have been observed

atmosphere

1/17/1969
T. I. Ladd
from T. Ladd

Proprietary

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12943

CERTIFICATE OF DEATH

Reg. Dist. No.

12902

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY PRINCE George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MARYLAND		b. COUNTY PRINCE Geo			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORESTVILLE		c. LENGTH OF STAY IN lb 2 YEARS 11 Mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HILL CREST Heights		d. STREET ADDRESS 5918-ST. CLAIR DRIVE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FORESTVILLE NURING HOME				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) JAMES Monroe McCawley		First	Middle	Last	4. DATE OF DEATH NOV - 2 - 1959	Month	Day	Year	
5. SEX MALE		6. COLOR, OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 6, 1876	9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>				Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRINTER (RETIRED)		10b. KIND OF BUSINESS OR INDUSTRY U.S. GOV		11. BIRTHPLACE (State or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME CHARLES M. MCCAWLEY		14. MOTHER'S MAIDEN NAME NANCY Riggsby		INFORMANT Bessie L. McCawley		Address same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X DUE TO CEREBRAL THROMBOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) GENERALIZED ARTERIOSCLEROSIS 15 yr. (c) _____									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? IF EITHER, NOTIFY MEDICAL EXAMINER YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 4-3 , 19 53 , to 11-2 , 19 59 , that I last saw the deceased alive on 11-1 , 19 59 , and that death occurred at 1230 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2210 NICHOLS AVE S.E WASH D.C. DATE SIGNED John B Feegan									
ACTUAL SIGNATURE John B Feegan		M.D.							
PHYSICIAN'S NAME (Type) JOHN B FEEGAN, MD		22a. BURIAL, CREMATION, REMOVAL Burial Nov 5-59 22b. DATE THEREOF Nov 5-59 22c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery 22d. LOCATION (City, town, or county) (State) Glenwood, Maryland							
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros		ADDRESS 1661 9000 Hope Rd SE		24a. REC'D BY REGISTRAR DATE NOV 4 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Knapp			

HTAG TO STATION



1 R

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

12903

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. STREET ADDRESS 1413 Boones Hill Road, Apt.#1	
3. NAME OF DECEASED (Type or print)	First EDWARD	Middle JOSEPH	Last MC GEE, JR.
4. DATE OF DEATH	Month November	Day 27th,	Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Feb. 24th, 1914
9. AGE (In years last birthday) 45 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Hours 0	12. IF UNDER 24 HRS. Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gas Station Attendant		10b. KIND OF BUSINESS OR INDUSTRY Basoline	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Joseph McGee		14. MOTHER'S MAIDEN NAME Elizabeth Liversedge	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. 578-01-8394	
17. INFORMANT Edward J. McGee III, 1413 Boones Hill Rd.S.E.		Address Washington 27, D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure			
410X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
(b) Ulcerated mitral stenosis			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>James I. Boyd</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED Nov. 28th, 1959
EXAMINER'S NAME (Type) James I. Boyd			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov 30, 1959	22c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	24a. REC'D BY REGISTRAR DATE DEC 1 '59
			24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V.S. ATISME
5M 2/57

REVIEW OF THE EXAMINER'S CRITIQUE OF DEATH
WILLIAM H. DAVIS AND ROBERT E. BERNONE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12904

X 1
 FOR STATE
 HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

12856		12904											
1. PLACE OF DEATH a. COUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN 1b 21 years.											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3513 54th Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) Juanita Crenshaw		First Juanita	Middle Crenshaw	Last McKibben	4. DATE OF DEATH November 5, 1959	Month November	Day 5	Year 1959					
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 7-28-27	9. AGE (In years last birthday) 32 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. Hours 0	13. MIN. Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) S. Carolina		12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME John Samuel Crenshaw		14. MOTHER'S MARRIED NAME Elizabeth Blanche											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 248-34-2563		17. INFORMANT William B. McKibben; same address as #2.		Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 976x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hemorrhage and shock DUE TO Gunshot wound of chest (c)									INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self inflicted wound of chest											
20c. TIME OF INJURY Hour 10.30 a.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) Hyattsville			(County) Pr. Geo.		(State) Md.		
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>John T. Maloney</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							DATE SIGNED November 5, 1959				
EXAMINER'S NAME (Type) John T. Maloney, M.D.		22c. NAME OF CEMETERY OR CREMATORIUM Unity Cemetery							22d. LOCATION (City, town, or county) Ft. Mill				
22a. REMOVAL (Specify) Removal		22b. DATE THEREOF Nov. 9, 1959		22d. LOCATION (City, town, or county) So. Carolina		(State)							
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR Arthur S. Thomas		24b. REGISTRAR'S SIGNATURE							
VS. A15ME 5M 2/57		DATE NOV 10 '59		DATE NOV 10 '59									

www.fcc.gov

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

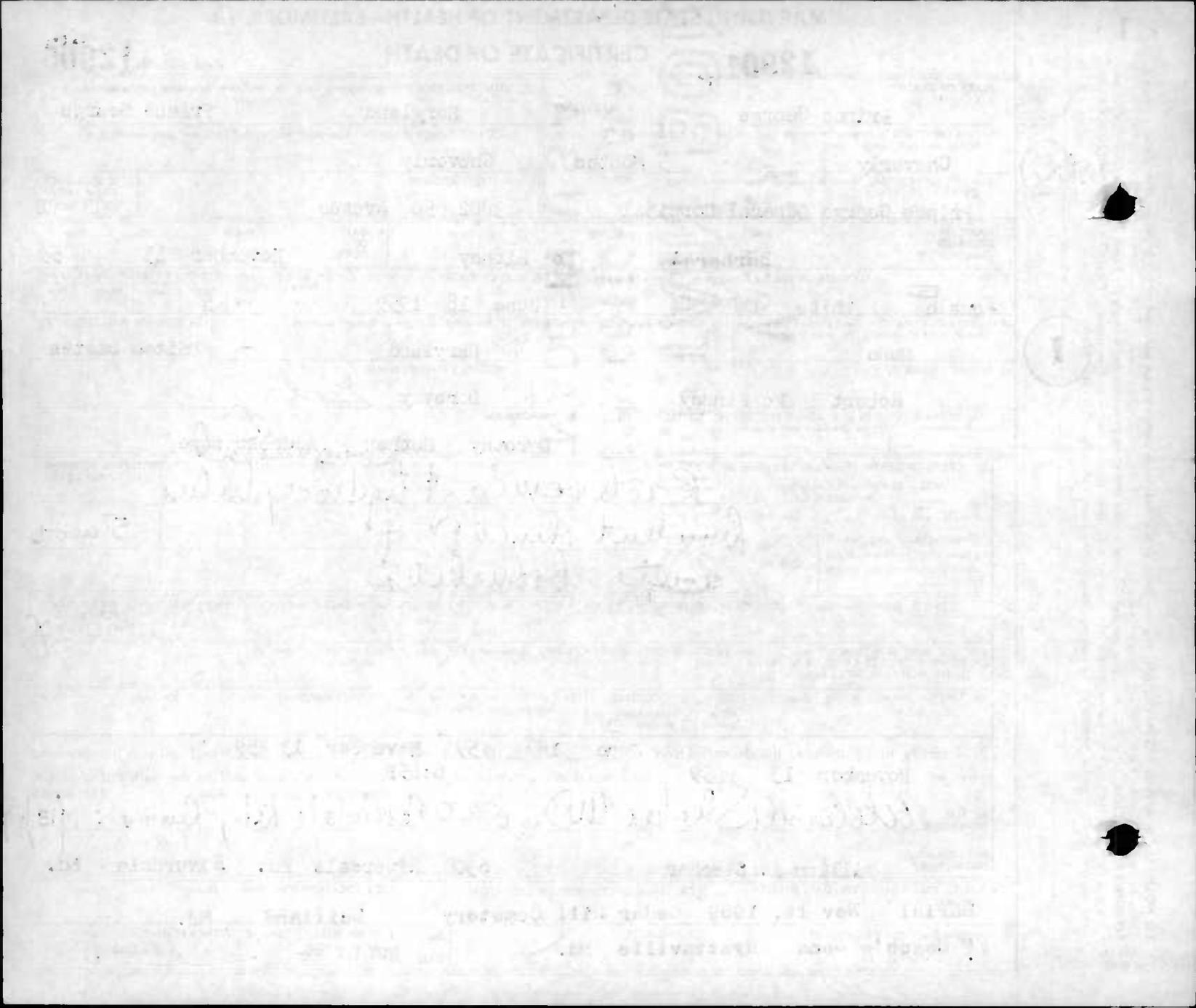
12901

CERTIFICATE OF DEATH

Reg. Dist. No. 12905

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Prince George		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 5 Months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Barbara	Middle Mc Kinney	4. DATE OF DEATH Month November Day 13 Year 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 18 1959
9. AGE (In years last birthday) yrs. 5	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? United States		13. FATHER'S NAME Robert L. Mc Kinney	
14. MOTHER'S MAIDEN NAME Dorothy Godsey		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO.		INFORMANT Dorothy Mother	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 512.1		INTERVAL BETWEEN ONSET AND DEATH Bacteremia & hydrocephalus 5 mos.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO C. DUE TO (c) acute bronchitis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 18, 1959 , to November 13, 1959 , that I last saw the deceased alive on November 13, 1959 , and that death occurred at 6:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE William A. Stecher M.D.		ADDRESS (Street, city or town, state) 6300 Riverdale Rd., Riverdale Md.	
PHYSICIAN'S NAME (Type) William A. Stecher		DATE SIGNED 11/18/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 16, 1959	
22c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		24a. REC'D BY REGISTRAR DATE NOV 17 '59	
ADDRESS Hyattsville Md.		24b. REGISTRAR'S SIGNATURE John L. Koenig	



1X

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12906

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince George</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) b. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chesapeake</i>		c. LENGTH OF STAY IN 1b <i>20 days</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>14 College Park</i>		d. COUNTY <i>P.G. Co.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Prince George's Gen. Hosp.</i>		e. STREET ADDRESS <i>4835 - Indian Lane</i>	
3. NAME OF DECEASED (Type or print)		First <i>James</i>	Middle <i>Arthur</i>
Last <i>Melton</i>		4. DATE OF DEATH <i>Nov. 30</i>	Month <i>Nov.</i> Day <i>30</i> Year <i>1959</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
			8. DATE OF BIRTH <i>10-23-12</i>
		WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Shipping Clerk</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Electronics</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
13. FATHER'S NAME <i>Arthur Melton</i>		14. MOTHER'S MAIDEN NAME <i>Laura Dison</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <i>No</i>		16. SOCIAL SECURITY NO.	17. INFORMANT <i>Louise Leijian</i>
			Address <i>College Park, Md.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>443X</i>		DUE TO <i>Acute congestive heart failure</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) <i>Hypertensive cardiovascular disease</i>	
DUE TO		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Polycystic kidneys. Coronary atherosclerosis</i>	
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <i>Hyattsville</i> (County) <i>Md.</i> (State) <i>Md.</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>		DATE SIGNED <i>Dec. 1, 1959</i>	
ACTUAL SIGNATURE <i>John J. Maloney</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>JOHN J. MALONEY, M.D.</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Dec 2, 1959</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>George Washington</i>		22d. LOCATION (City, town, or county) <i>Hyattsville Md.</i> (State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Gasch's Sons</i>		ADDRESS <i>Hyattsville Md.</i>	
		24a. REC'D BY REGISTRAR DATE <i>DEC 3 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>

UNIVERSITY OF TORONTO LIBRARIES
EXHIBITAL EXAMINER'S CERTIFICATE OF DETAIL



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12944

CERTIFICATE OF DEATH

Reg. Dist. No.

12907

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, file the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE DISTRICT OF COLUMBIA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - GLENN DALE		c. LENGTH OF STAY IN 1b 7 yrs, 1 mo, 4 wks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GLENN DALE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) NELLIE		First C.	Middle MENDER
Last HALL		4. DATE OF DEATH Month NOV	Day 21
Year 1959		5. SEX FEMALE	6. COLOR OR RACE WHITE
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/9/07	9. AGE (In years lost birthday) 52 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEAMSTRESS		10b. KIND OF BUSINESS OR INDUSTRY SELF-EMPLOYED	11. BIRTHPLACE (State or foreign country) SALISBURY, NORTH CAR.
13. FATHER'S NAME JOHN W. KERR		14. MOTHER'S MAIDEN NAME CLARA SWAIN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. UNK.	INFORMANT PATIENT
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY TUBERCULOSIS		INTERVAL BETWEEN ONSET AND DEATH 8 YRS.	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) PULMONARY INSUFFICIENCY AND COR PULMONALE			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from OCT 17, 1952 , to NOV 21, 1959 that I last saw the deceased alive on NOV 21, 1959 , and that death occurred at 110A M from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Moe Weiss</i>		ADDRESS (Street, city or town, state) M.D. GLENN DALE HOSPITAL	
PHYSICIAN'S NAME (Type) MOE WEISS, M.D.		DATE SIGNED <i>11/28/59</i>	
22a. BURIAL CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 11-23-59	22c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln
22d. LOCATION (City, town, or county) Colman Manor, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE F. Hachis Louis 4739 Bell. Av., Hyattsville		24a. REC'D BY REGISTRAR DATE NOV 27 '59	24b. REGISTRAR'S SIGNATURE Cinithia S. Krause

BRIEVE GEGESEN
DISTRICT C 7 CARRARIA
KURIR. CERNA DATE JUN 1964
X FERN DATE MARCH 1964
22 NCA 31 22
MELFIE G. MENDEZ-HART
22 03 22
FERMATE WHUE X
A.Z.V. SERV-EMPLOYEE SURVEYS, WEST GAB
DEAWATREES
JOHN W. KERK GFTK4 SWAIN
NO
8 X 22
JUNIOR TUBERCULOSIS

BURGENLAND INSTITUTION AND CCB BURGENLAND
X
1964 22 NCA 31 22
GCD 13 22 NCA 31 22
GRENADA DATE MARCH 1964
W.D. GRENADA DATE MARCH 1964

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12908

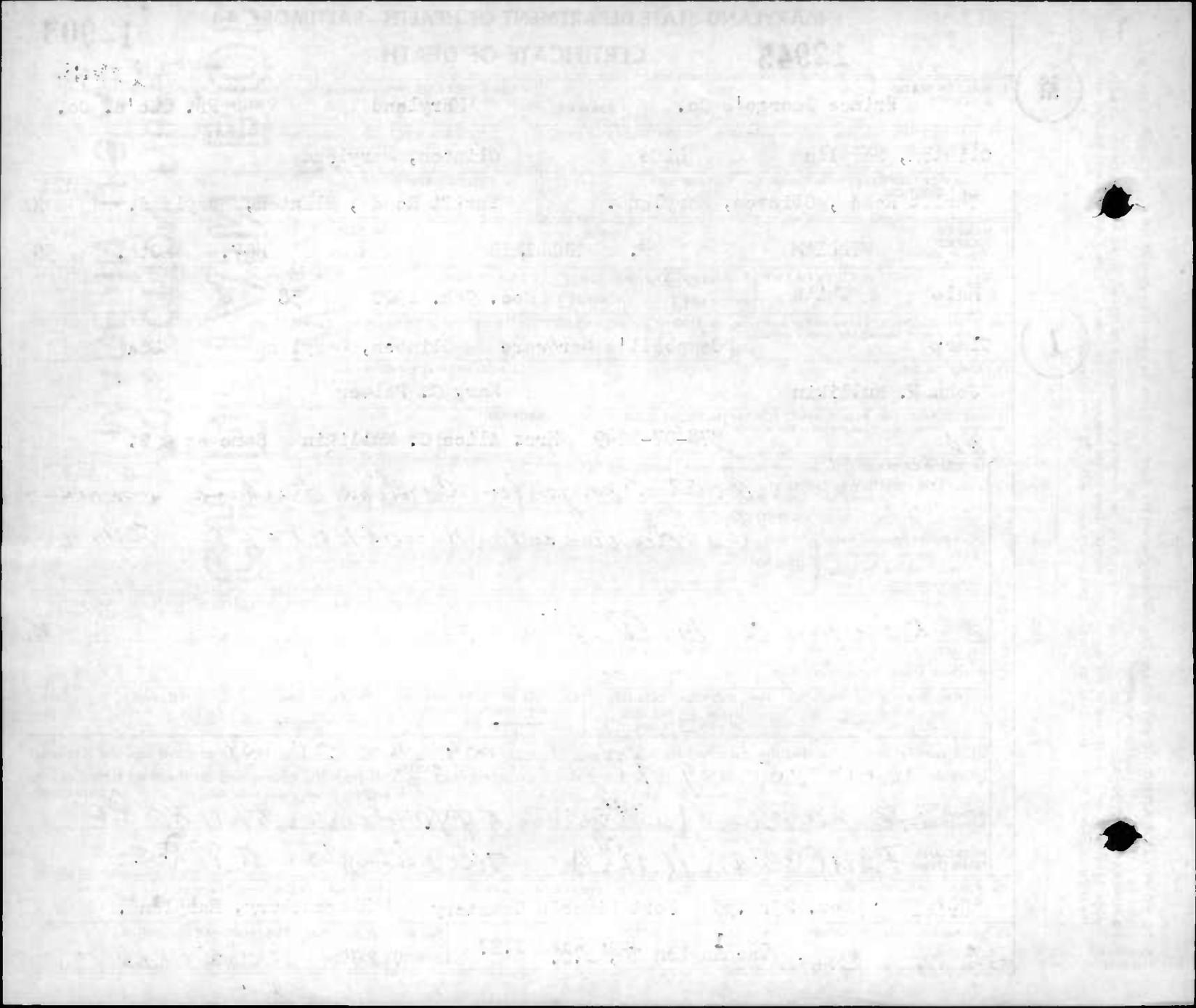
12945

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be retained by the hospital or attending physician; page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's. Co.	
b. CITY OR TOWN (If outside corporate limits, write PLURAL and give nearest town) Clinton, Maryland		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Thrift Road, Clinton, Maryland.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Clinton, Maryland	
3. NAME OF DECEASED (Type or print) WILLIAM		First F.	Middle MULLIKIN Last
4. DATE OF DEATH NOV. 20th.		Month	Day Year 19 59
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 9th. 1900
9. AGE (In years last birthday) 58 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Campbell's Hardware	
11. BIRTHPLACE (State or foreign country) Clinton, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John H. Mullikin		14. MOTHER'S MAIDEN NAME Mary O. Palmer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-07-2249	
17. INFORMANT Mrs. Alice C. Mullikin		Address Same as # 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Congestive Cardiac failure</i> 1 hour 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Cerebrovascular Neural Disease</i> 2 yrs DUE TO (c) _____			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetes Mellitus for one year</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II if item 18.) _____	
20c. TIME OF INJURY Month, Doy, Year Hour o. m. — 19 p. m. —		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) (County) (State) _____	
21. I certify that I attended the deceased from Jan 1, 1959, to Nov 20, 1959, that I last saw the deceased alive on Nov 15, 1959, and that death occurred at 3 p.m., from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>Paul C Van Natta</i> M.D. ADDRESS (Street, city or town, state) 5440 Silver Hill Rd SE PHYSICIAN'S NAME (Type) PAUL C VAN NATA Washington 28 DC			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 23rd. 59	
22c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) Bladensburg, Maryland. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Simmons Bros.</i>		1661 Good Hope Road S.E. ADDRESS Washington 20, D.C.	
24a. REC'D BY REGISTRAR DATE NOV 23 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Haas</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

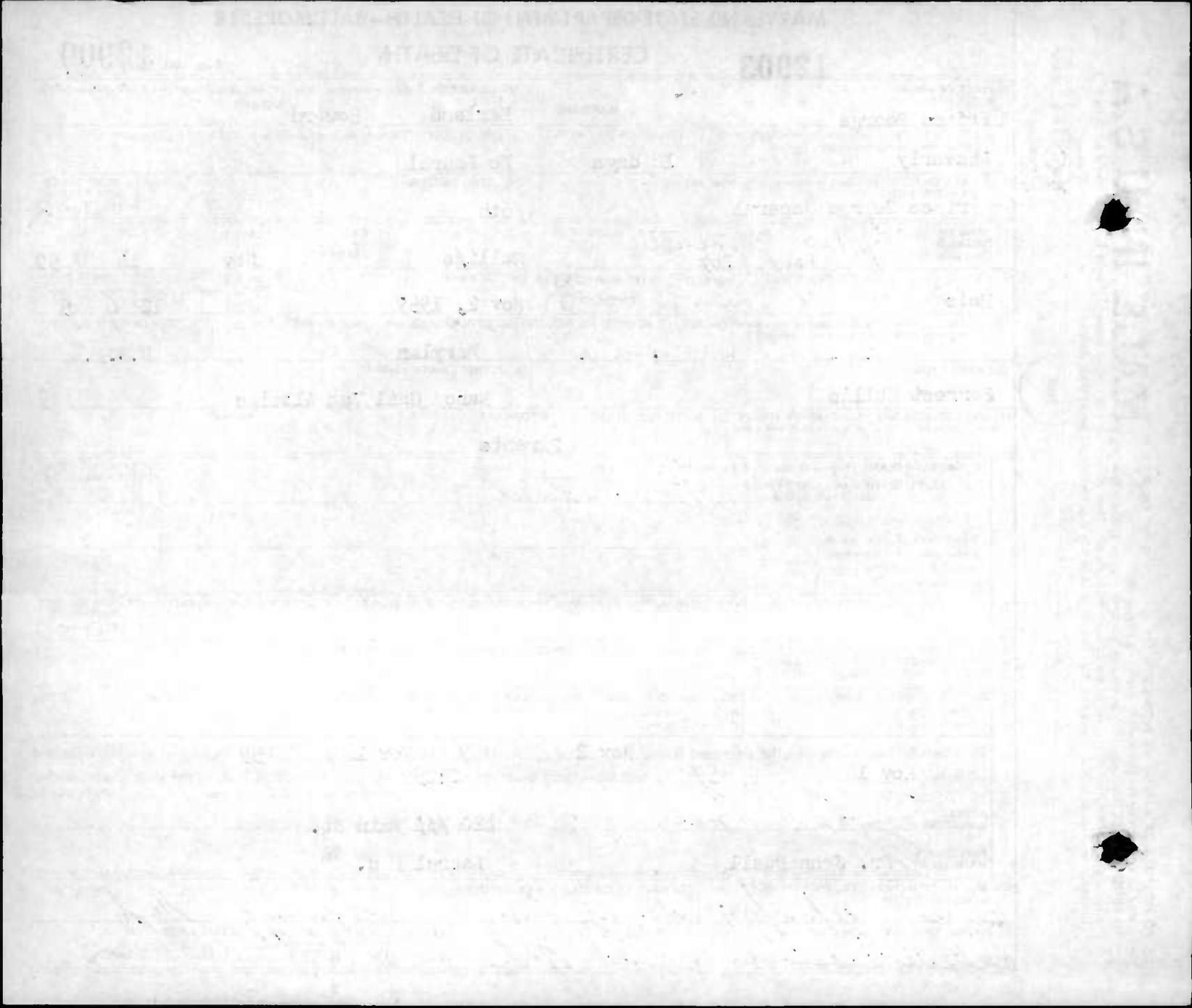
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **12909**

12903

1. PLACE OF DEATH a. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverley		c. LENGTH OF STAY IN 1b 12 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) No Laurel		d. STREET ADDRESS 6th			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First John	Middle Everett	Last Baby	4. DATE OF DEATH Mullis	Month Nov	Day 14	Year 1959	
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 2, 1959		9. AGE (In years lost birthday) yrs. 12	IF UNDER 1 YEAR Months 12	IF UNDER 24 HRS. Days 6	Hours 5	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Name		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Forrest Mullis				14. MOTHER'S MAIDEN NAME Nancy Gail Van Alstine		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT Parents					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X DUE TO <i>Prematurity</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) Laurel		(State)	
21. I certify that I attended the deceased from Nov 2, 1959 , to Nov 14, 1959 , that I last saw the deceased alive on Nov 14, 1959 , and that death occurred 2:25 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 120 Main St. DATE SIGNED John R. Buell									
ACTUAL SIGNATURE John R. Buell		M.D.							
PHYSICIAN'S NAME (Type) Dr. John Buell				Laurel M.d.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/16/59		22c. NAME OF CEMETERY OR CREMATORIAL Savage Cem		22d. LOCATION (City, town, or county) Savage Md (State)			
23. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Kranck		ADDRESS Arthur S. Kranck		24a. REC'D BY REGISTRAR DATE NOV 18 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kranck			
20 77234 X VI									



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12904

CERTIFICATE OF DEATH

12910

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
Prince George Co., MARYLAND		Maryland Prince Geo. Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Riverdale		23 Greenbelt	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
Leland Memorial Hosp.	1 56 C Ridge Rd		
3. NAME OF DECEASED (Type or print)	First	Middle	Last
James Michael Newcomb		November 12 1959	
4. DATE OF DEATH	Month	Day	Year
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
Male	white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	12-13-99
9. AGE (In years last birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.	
59 yrs.	Months Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
wine Foreman		C & P Telephone	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Virginia		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
John Edward Newcomb		Mary Magner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
(If yes, give war or dates of service)		17. INFORMANT	
		Hosp. Record - Leland Memorial Hosp.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Myocardial infarction</i>	
420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO	
{		(b) <i>Coronary thrombosis</i>	
DUE TO		(c) <i>Anteriorisclerotic heart disease</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-7-58</u> , 19 <u>58</u> , to <u>11-12</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11-12</u> , 19 <u>59</u> , and that death occurred at <u>4:15 P.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>D.R.Purdie</u>		M.D. <u>4404 Greensboro Rd, Riverdale, Md.</u> 11-12-59	
PHYSICIAN'S NAME (Type) <u>D. R. Purdie MD</u>			
22a. BURIAL, CREMATION, REMOVAL		22b. DATE THEREOF	
<u>Burial</u>		<u>11-16-59</u>	
22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State)	
<u>dark Lincoln Woods</u>		<u>Prince George Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
<u>B.G. Mittelly</u>		24b. REGISTRAR'S SIGNATURE	
ADDRESS <u>131-11th St. 8-E.</u>		DATE <u>NOV 16 '59</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

01 BROWNSVILLE - DEPARTMENT OF STATE DRAFTED BY DANIEL

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12911

12946

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
<i>Prince George MARYLAND</i>		<i>Maryland Prince Geo.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <i>Fairmount Hts. 5 yrs.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1032-58" Ave.</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Fairmount Heights</i>	
d. STREET ADDRESS <i>1032 - 58" Ave.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Middle Last	
<i>Bertha Nelson Norris</i>		4. DATE OF DEATH Nov. 30 1959	
5. SEX <i>Fe</i>		6. COLOR OR RACE <i>Hyrdo</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <i>8-3-1909</i>	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) yrs. <i>30</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Washington D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Robert Berry</i>		14. MOTHER'S MAIDEN NAME <i>Bertha Irene Forrest</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <i>Ethel M. Davis - 4020 Ala. Ave. SE</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per-line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>443X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive Cardio-Vascular Disease</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>28</i>			
DUE TO <i>C. V. A. Hemorrhage 10/18/59</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) DUE TO <i>(c)</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>11-20- 1959</i> , to <i>11-30- 1959</i> , that I last saw the deceased alive on <i>11-20- 1959</i> , and that death occurred at <i>7: P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>John W. Robinson, M.D.</i> ADDRESS (Street, city or town, state) <i>1001 Eastern Ave. N.E. 11/20/59</i> DATE SIGNED <i>11/20/59</i>			
22a. PHYSICIAN'S NAME (Type)		22b. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial 12/15/59</i>	
22c. DATE THEREOF <i>12/15/59</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Woodlawn</i>	
22d. LOCATION (City, town, or county) <i>Wash. D.C.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John G. Stewart - 30 Hyatt St.</i>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <i>DEC 3 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, file in the funeral director's office. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15 (4)
15M 9/55

CERTIFICATE OF DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the state department.

STATE
TH DEPT.

or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1285 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12912

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Rainier		c. LENGTH OF STAY IN 1b 52 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 16 Mount Rainier				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4208 34th Street				d. STREET ADDRESS 4208 34th Street				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)		First Edward	Middle Calvin	Last Norton	4. DATE OF DEATH Nov. 11	Month Nov.	Doy 11	Year 1959
5. SEX Male		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 12/26/06	9. AGE (In years last birthday) 52 yrs.	IF UNDER 1 YEAR Months 52	IF UNDER 24 HRS. Hours 52	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stone mason		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Amos Leonard Norton				14. MOTHER'S MAIDEN NAME Grace L.				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 219-03-4331 17. INFORMANT Address 5707 Longfellow Bernadine M. Parnell; Riverdale, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost.				Acute congestive heart failure Cardiovascular renal disease				
INTERVAL BETWEEN ONSET AND DEATH								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>John J. Maloney</i>				DATE SIGNED				
EXAMINER'S NAME (Type) John T. Maloney, M.D.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/16/59		22c. NAME OF CEMETERY OR CREMATORIAL Arlington National		22d. LOCATION (City, town, or county) Arlington, Virginia (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Malley's Funeral Home				ADDRESS Mount Rainier 24a. REC'D BY REGISTRAR Arthur & Francis 24b. REGISTRAR'S SIGNATURE Arthur & Francis				
Sue.				DATE NOV 16 '59				

EXAMINER'S CERTIFICATE OF DEATH

NAME	ADDRESS	NAME	ADDRESS
AGE	SEX	AGE	SEX
DEATH DATE	TIME	DEATH DATE	TIME
CAUSE OF DEATH	CAUSE OF DEATH	CAUSE OF DEATH	CAUSE OF DEATH
DEATH CERTIFIED	DEATH CERTIFIED	DEATH CERTIFIED	DEATH CERTIFIED
PRINTED NAME	PRINTED NAME	PRINTED NAME	PRINTED NAME
STAMP	STAMP	STAMP	STAMP
REASON FOR EXAMINATION			
<input type="checkbox"/> Autopsy			
<input type="checkbox"/> Death certificate			
<input type="checkbox"/> Medical certificate			
<input type="checkbox"/> Other			
SIGNATURE			

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V.S. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12905

12913

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON 47x-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. STREET ADDRESS 341-11th. St. S.E.	
3. NAME OF DECEASED (Type or print) First NICOLOS Middle LEE Last ORES		4. DATE OF DEATH Month November Day 5th, Year 19 59	
5. SEX Male		6. GONE TO STATE WALLES	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH July 5, 1920	
9. AGE (In years last birthday) 39 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) GEORGIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT Address Wash. Idell Ores (Wife) 341-11th. St. S. E. D. C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis		INTERVAL BETWEEN ONSET AND DEATH	
420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary athero-sclerosis			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		DATE SIGNED Nov. 5th, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-12-59	
22c. NAME OF CEMETERY OR CREMATORIAL Woodlawn		22d. LOCATION (City, town, or county) WASHINGTON, D.C. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE John T. Rhines & Co-345-1245		ADDRESS	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Arthur L. Trahan	
DATE NOV 12 '59			

WISCONSIN'S CULTURE OF DEATH - A HISTORY OF HUMAN RELATIONS IN MEDICAL CARE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12914

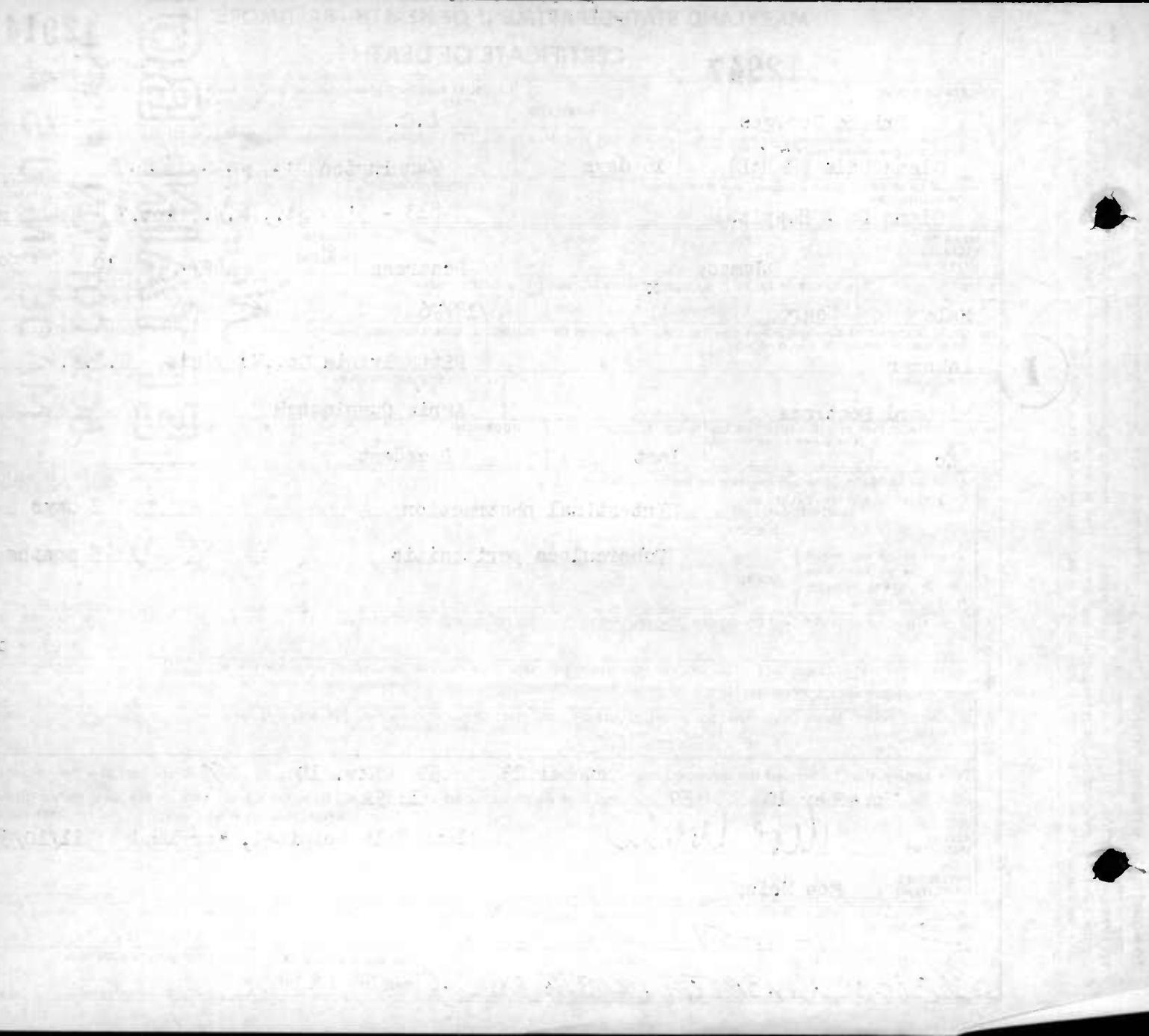
CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D.C.		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (RURAL)		c. LENGTH OF STAY IN 1b 18 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington St. Apt. 47X-3				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		d. STREET ADDRESS 813 - 51st St., N.W., Apt. 7		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) James		First	Middle	Last	4. DATE OF DEATH Peatross	Month Nov.	Day 10	Year 1959
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 8/18/96	9. AGE (In years lost birthday) 63 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Pittsylvania Co., Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Richard Peatross		14. MOTHER'S MAIDEN NAME Annie Cunningham		INFORMANT Decedent		Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. lost		17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 011X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Tuberculous peritonitis (c)		INTERVAL BETWEEN ONSET AND DEATH 2 days		
18. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) No		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. Day p. m. Year 19		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) Glenn Dale Hospital, Maryland		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21. I certify that I attended the deceased from October 23, 1959 , to Nov. 10, 1959 , that I last saw the deceased alive on November 10, 1959 , and that death occurred at 1:15 AM , from the causes and on the date stated above. ACTUAL SIGNATURE Moe Weiss		ADDRESS (Street, city or town, state) Glenn Dale Hospital, Maryland		DATE SIGNED 11/10/59				
PHYSICIAN'S NAME (Type) Moe Weiss		22a. BURIAL CREMATION, REMOVAL (Specify) 11-16-59		22b. DATE THEREOF Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.		
23. FUNERAL DIRECTOR'S SIGNATURE George L. Better 1203 Wallard St		ADDRESS 813 - 51st St., N.W., Apt. 7		24a. REC'D BY REGISTRAR NOV 16 '59		24b. REGISTRAR'S SIGNATURE Arthur & Thorne		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12905 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12915

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending", in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File Pages 1 and 2 with the registrar prior to burial, cremation or removal.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Prince Georges MARYLAND		a. STATE MARYLAND	b. COUNTY PRINCE GEORGES
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly	c. LENGTH OF STAY IN 1b D.O.A.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. 47x-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 1103 50th Place	
3. NAME OF DECEASED (Type or print) James Albert Pinkney	First James	Middle Albert	Last Pinkney
4. DATE OF DEATH November 17 1959	Month November	Day 17	Year 1959
5. SEX Male	6. COLOR OR RACE Col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 2-21-1896
9. AGE (in years last birthday) 63	10. IF UNDER 1 YEAR Months 63	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck driver		10b. KIND OF BUSINESS OR INDUSTRY Drayage	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Pinkney		14. MOTHER'S MAIDEN NAME Minnie Hawkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W. 1 579-01-462	
17. INFORMANT Beatrice Pinkney; same address as # 2.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Shock INTERVAL BETWEEN ONSET AND DEATH			
442X DUE TO Ruptured heart			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
Diabetes mellitus			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John T. Maloney</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED
EXAMINER'S NAME (Type) John T. Maloney, M.D.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-20-59	22c. NAME OF CEMETERY OR CREMATORIAL Arlington National
22d. LOCATION (City, town, or county) Arlington, Va.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Myrtle K. Hollins		ADDRESS 4339 HuntPl., N.E.	24a. REC'D BY REGISTRAR NOV 23 '59
			24b. REGISTRAR'S SIGNATURE <i>Lucille L. Thomas</i>

STATE OF GEORGIA
GENERAL EXAMINERS CERTIFICATE

111

1000

1000

1000

1000

1000

1000

1000

1000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 Film G252 11-16-59 et

CERTIFICATE OF DEATH

Reg. Dist. No.

12916

12948

1. PLACE OF DEATH

o. COUNTY

Prince Geo.

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Clinton

c. LENGTH OF STAY IN 1b

1 month

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

St. Md. Hosp Center

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)

o. STATE

Maryland

b. COUNTY

Prince George's

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Upper Marlboro

d. STREET ADDRESS

RT #1 Box 278A

e. IS RESIDENCE ON A FARM?

YES NO 3. NAME OF DECEASED
(Type or print)

First

Middle

Last

4. DATE OF DEATH

Month Nov

Day 7

Year 1957

5. SEX

M

6. COLOR OR RACE

Colored

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

Dec 12th 1883

9. AGE (In years last birthday) 75 yrs.

10. IF UNDER 1 YEAR IF UNDER 24 HRS.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

FARMER

10b. KIND OF BUSINESS OR INDUSTRY

FARMING

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Thomas Marcellous Proctor

14. MOTHER'S MAIDEN NAME

Elizabeth M. Proctor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

No.

16. SOCIAL SECURITY NO.

220-01-51788

INFORMANT

Daughter, Georgeanna Baker Upper Marlboro

Address

RT#1 Box 278A

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

610X

DUE TO

Pulmonary embolus

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

Post operative suprarenal

(c)

bic prostatectomy

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

generalized arteriosclerosis

19. WAS AUTOPSY PERFORMED?
YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. m.
p. m.20d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)
(County)
(State)

21. I certify that I attended the deceased from

alive on 11-6-59, and that death occurred at

11-7-59, to

7P

M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL SIGNATURE

A. SAMADI

M.D.

11-8-59

PHYSICIAN'S NAME (Type)

LEONARDTOWN - Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

Burial

11-10-59

22c. NAME OF CEMETERY OR CREMATORIUM

Rosaryville Cem

22d. LOCATION (City, town, or county, state)

Upper Marlboro, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Hundt Funeral Home, Waldorf, MD

24a. REC'D BY REGISTRAR

DATE NOV 12 '59

24b. REGISTRAR'S SIGNATURE

Arthur S. Traas

~~act~~ visit

~~and~~ will

W.M. & Mrs. H. L. Smith
and Mr. & Mrs. W. C. Smith
and Mr. & Mrs. W. C. Smith

W.M. & Mrs. H. L. Smith
and Mr. & Mrs. W. C. Smith

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12907 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12917

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PM3. Page 5 may be retained for your information, or removal.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institutional, Residence before admission) a. STATE	
<i>Prince Georges</i> Maryland		Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <i>Chesapeake</i> D.O.G.	
Chesapeake		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chesapeake</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
<i>Prince Georges Gen. Hosp.</i>		Box 648-A	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
<i>Dorothy</i>		Ramsey	Nov. 22
4. DATE OF DEATH		Month	Day
Nov. 22		Year	1959
5. SEX		6. COLOR OR RACE	
Female		White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
Widowed <input type="checkbox"/>		Divorced <input type="checkbox"/>	
Oct. 25, 1959			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
None			
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Maryland		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>John Ramsey</i>		<i>Frances Virginia Korn</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
No		If yes, give war or dates of service	
17. INFORMANT		Address	
<i>John Ramsey</i>		<i>Same address</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)			
763.0 DUE TO <i>Congestive heart failure</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
(b) DUE TO <i>Bronchopneumonia</i>			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . John J. Maloney ACTUAL SIGNATURE		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
JOHN J. MALONEY, M.D.		DATE SIGNED <i>November 22, 1959</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		Nov. 24, 1959	
22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State)	
Evergreen Cemetery		Bladensburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Mrs. Gasch's Sons		Hyattsville, Md.	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
VS. A15ME(5) 5M 9/55		DATE NOV 30 '59	
<i>2077369XUS</i>		<i>Arthur L. Traue</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12908 CERTIFICATE OF DEATH

12918

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George			MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland			b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN TB 0		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkway Estates						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 4826 67th Ave.						
3. NAME OF DECEASED (Type or print)		First Laura	Middle Ann	Last Rasmussen	4. DATE OF DEATH Nov. 8		Month Nov.	Day 8	Year 1959		
5. SEX		6. COLOR OR RACE Female	White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 15, 1959		9. AGE (In years last birthday) yrs. 19	IF UNDER 1 YEAR Months 0		IF UNDER 24 HRS. Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Md			12. CITIZEN OF WHAT COUNTRY? U S A		
13. FATHER'S NAME James Rasmussen					14. MOTHER'S MAIDEN NAME Mary Hince						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. no		INFORMANT Father		Address Same as no 2				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonitis 492X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)											INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)								
20c. TIME OF INJURY Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Cheverly		(County) Md	(State) MD	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on Nov 8 , 19 59 , and that death occurred at 9:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Bertha Van Gelderen M.D. 3021 Cheverly Ave Cheverly Md											DATE SIGNED 11/13/59
ACTUAL SIGNATURE Bertha Van Gelderen		PHYSICIAN'S NAME (Type) Bertha Van Gelderen									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF nov 12, 1959		22c. NAME OF CEMETERY OR Crematory Arlington National			22d. LOCATION (City, town, or county) Arlington			(State) Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE NOV 13 '59			24b. REGISTRAR'S SIGNATURE John G. King		

2008



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 12919

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Ohio</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>	c. LENGTH OF STAY IN lb <i>6 weeks</i>	b. COUNTY <i>Summit Co.</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Akron</i>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1304 Legation Road</i>	e. STREET ADDRESS <i>981 Hunt Street</i>	d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Mary Delice</i>	First <i>Mary</i>	Middle <i>Delice</i>	Last <i>Rhodes</i>
4. DATE OF DEATH <i>11-28-1959</i>	Month <i>11</i>	Day <i>28</i>	Year <i>1959</i>
S. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9/12/95</i>
9. AGE (In years lost birthday) yrs. <i>64</i>	10. USUAL OCCUPATION (Give kind of work done during man of working life, even if retired) <i>Retired School Teacher Akron, O.</i>	11. KIND OF BUSINESS OR INDUSTRY <i>Thompson, Ohio U.S.</i>	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <i>Gurnsey G. Whipple</i>	14. MOTHER'S MAIDEN NAME <i>Agnes Richards</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>269-12-7904</i>	INFORMANT <i>Mrs. Jean Crusan</i>	17. ADDRESS (Street or foreign country) <i>1304 Legation Rd Hyattsville Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>MANITON + CARDIAC FAILURE</i>			
DUE TO <i>155.1</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>CARCINOMA COMPLEX BILI DUCT</i>			
DUE TO <i>with metastases</i>			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Oct. 5, 1959</i> , to <i>Nov. 1959</i> that I last saw the deceased alive on <i>21 Nov. 1959</i> , and that death occurred at <i>11:45 AM</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>205 Sheridany St.</i>	
ACTUAL SIGNATURE <i>Henry R. Wolfe</i>		DATE SIGNED <i>11/28/59</i>	
PHYSICIAN'S NAME (Type) <i>HENRY R. WOLFE M.D.</i>		M.D. <i>H. Hyattsville, MD</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Dec. 1/59</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Mt. Peace</i>		22d. LOCATION (City, town, or county) <i>Akron Ohio</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Nalley's Funeral Home Inc.</i>		24a. REC'D BY REGISTRAR <i>Arthur S. Kraus</i>	
ADDRESS <i>Mt. Rainier Md.</i>		DATE <i>DEC 2 '59</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

1982
COMMITTEE TO DEFEND THE STATE OF ISRAEL

17AUG 30 STAMPED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12949

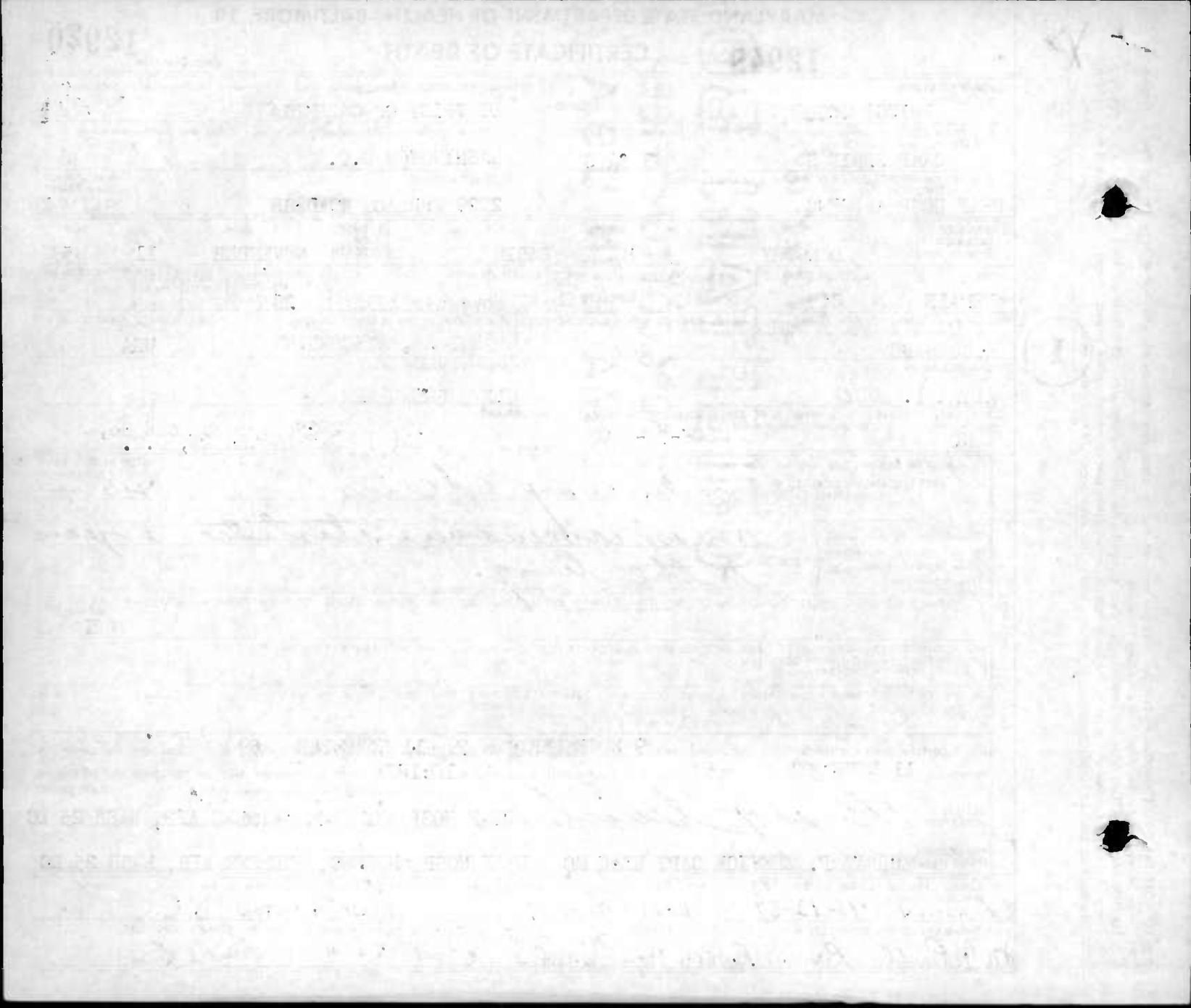
CERTIFICATE OF DEATH

Reg. Dist. No.

12920

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DISTRICT OF COLUMBIA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS		c. LENGTH OF STAY IN 1b 3 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSP ANDREWS,		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON D.C.	
3. NAME OF DECEASED (Type or print) DOROTHY		First M	Middle SABIN
S. SEX FEMALE	6. COLOR OR RACE CAU	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 1 November 1931
9. AGE (In years last birthday) 28 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	11. KIND OF BUSINESS OR INDUSTRY N/A	12. BIRTHPLACE (State or foreign country) HARTFORD, WISCONSIN
13. FATHER'S NAME ALTHA I. RUBY	14. MOTHER'S MAIDEN NAME OLIVE BREWBAKER		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. 508-34-6302	INFORMANT ROBERT C SABIN(H)	Address 2729 Terrace Road Se, Washington 20, D.C.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X DUE TO pulmonary edema INTERVAL BETWEEN ONSET AND DEATH+ Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Breast carcinoma metastatic 2 years			
DUE TO to the lung.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 9 NOVEMBER , 19 59, to 11 NOVEMBER , 19 59, that I last saw the deceased alive on 11 NOVEMBER , 19 59, and that death occurred at 10:19 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Murray Shevick</i>			ADDRESS (Street, city or town, state) M.D. USAF HOSP ANDREWS, ANDREWS AFB, WASH 25 DC
DATE SIGNED 11-12-59			
PHYSICIAN'S NAME (Type) MURRAY P. SHEVICK CAPT USAF MC USAF HOSP ANDREWS, ANDREWS AFB, WASH 25 DC			
22a. BURIAL, CREMATION REMOVAL (Specify) CREMATION	22b. DATE THEREOF 11-12-59	22c. NAME OF CEMETERY OR CREMATORIAL LEE'S CEMETORY	22d. LOCATION (City, town, or county) WASH. D.C. (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>M. J. Rinaldi</i>		ADDRESS Rinaldi Funeral Home WASH. 2. D.C.	24a. REC'D BY REGISTRAR NOV 13 '59
			24b. REGISTRAR'S SIGNATURE <i>Arthur S. Trahan</i>



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded with the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your records. To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar or record.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12921

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission)	
<i>Prince Georges</i>		a. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Cherryly</i>	<i>806</i>	<i>38 Cherryly</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
<i>Prince Georges Gen-Hosp</i>		<i>13007-Parkway</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
<i>Arthur Charles Schalk</i>			
4. DATE OF DEATH		Month	Day Year
		<i>Nov</i>	<i>14 1959</i>
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
<i>Male</i>		<i>White</i>	<i>Civil 10.1896</i>
8. DATE OF BIRTH		9. AGE (in years last birthday)	10. IF UNDER 1 YEAR Months Days Hours Min.
		<i>63 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
<i>Special Police</i>		<i>U.S. Govt.</i>	<i>Ohio</i>
12. CITIZEN OF WHAT COUNTRY?		<i>U.S.A.</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>William Schalk</i>		<i>Margaret Wentz</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
<i>Yes</i>		<i>W.W.I</i>	
17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	
		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	
<i>442X</i>		<i>Acute congestive heart failure</i>	
DUE TO			
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		<i>Cardiovascular renal disease</i>	
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
19			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>John T. Maloney</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>JOHN T. MALONEY - M.D.</i>		DATE SIGNED <i>November 14, 1959</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11/18/59</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Arlington National</i>		22d. LOCATION (City, town, or county) <i>Arlington, Va.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Malley's Funeral Home Inc.</i>		ADDRESS <i>Mt. Rainier Md.</i> REC'D BY REGISTRAR <i>NOV 18 1959</i> 24b. REGISTRAR'S SIGNATURE <i>Malley & Sons</i>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be referred to the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 Item 9 FilmG251 11-10-59 et
CERTIFICATE OF DEATH

12922
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 1 Day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) W. Hyattsville 15		d. STREET ADDRESS 5723 Chillum Heights Drive	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Eunice	Middle E	Last Shaver	4. DATE OF DEATH Nov. 1	Month Nov.	Day 1	Year 19 59
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 12/18/08	9. AGE (In years last birthday) 50 49 yrs.	IF UNDER 1 YEAR Months 50	IF UNDER 24 HRS. Days 49	Hours hrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME A. M. Mc Comas			14. MOTHER'S MAIDEN NAME Vesta Nelson				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Unk		INFORMANT Delbert E Shaver		Address Hyattsville Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO 410X INTERVAL BETWEEN ONSET AND DEATH 24 hours							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Mitral Stenosis & Patent Foramen Ovale years (c) Chronic Rheumatic Heart Disease years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> Pulmonary Emphysema due to Chronic Bronchitis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 19.59		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 1959 to Nov. 1, 1959 that I last saw the deceased alive on November 1, 1959 , and that death occurred at 1:25 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE William D. Rosson, M.D. ADDRESS (Street, city or town, state) 5304 Annapolis Road Bladensburg, Maryland DATE SIGNED							
PHYSICIAN'S NAME (Type)		Dr. Rosson, M.D.					
22a. BURIAL, CREMATION, REMOVAL & REMOVAL (Specify) Burial		22b. DATE THEREOF 11/5/59		22c. NAME OF CEMETERY OR CREMATORIAL Rester Funeral Home		22d. LOCATION (City, town, or county) (State) Akron Ohio	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE NOV 5 1959		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	

01081

and receiving and sending
and delivering and sending

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12923

12950

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berwyn Heights, Md.		c. LENGTH OF STAY IN lb 40 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8515 60th Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Annie	Middle	Last Smith
4. DATE OF DEATH	Month November	Day 25, 19 59-	Year
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 30, 1873
9. AGE (In years last birthday) 86 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. KIND OF BUSINESS OR INDUSTRY own home	12. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME ?	14. MOTHER'S MAIDEN NAME Clodgett Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. none	INFORMANT Paul J McCullough, Berwyn Heights, Md.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Myocardial Infarction			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH Years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Injury from falls	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Laurel, Md.
20f. (City or town) Laurel, Md.	(County) Calvert Co.	(State) Md.	
21. I certify that I attended the deceased from Oct 28, 1959 to Nov 25, 1959 , hot I lost saw the deceased alive on Oct 28, 1959 and that death occurred at 10 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Laurel, Md.			
DATE SIGNED Nov 26, 1959			
ACTUAL SIGNATURE 		PHYSICIAN'S NAME (Type) Robert C Wingfield	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 28, 1959	22c. NAME OF CEMETERY OR CREMATORIUM New Cathedral Cemetery
22d. LOCATION (City, town, or county) Baltimore, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Maryland.	24a. REC'D BY REGISTRAR DATE NOV 30 '59
		24b. REGISTRAR'S SIGNATURE C. L. Trahan	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 1 FilmG252 11-16-59 et
CERTIFICATE OF DEATH

ITEM 1 FILM G252 11-16-59 e

12924

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12925

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 1 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Adsacorda Nursing Home		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Levy		First Newton	Middle Stely
Last		4. DATE OF DEATH Nov 21 Day Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 13, 1868
9. AGE (In years last birthday) 91 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Penn.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
INFORMANT Phillip S. Brooke		Address 4720 Eastern Av. NE.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
420.0 DUE TO Congestive Heart Failure 2 weeks			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arteriosclerotic Heart Disease 2 yrs t			
DUE TO (c) Generalized Arteriosclerosis 10 yrs +			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1958, to 11/20, 1959, that I last saw the deceased alive on 11/20, 1959, and that death occurred at 935A M, from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) DATE SIGNED Frank M. Trozzo, M.D. 3501 Hamilton St 11/21/59			
ACTUAL SIGNATURE			
PHYSICIAN'S NAME (Type) FRANK M. TROZZO Hyattsville, Md			
22a. BURIAL, CREMATION, BURIAL (Specify) Burial		22b. DATE THEREOF 11/24/59	
22c. NAME OF CEMETERY OR CREMATORIAL Flint Hill Cem.		22d. LOCATION (City, town, or county) Oakton, Va. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home		ADDRESS 4th & Mass Ave. N. E.	24a. REC'D BY REGISTRAR DATE NOV 25 '59
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

and I will take care
of you and I will take care
of you and I will take care

PC 02/11 - 8291
PC 02/11 - 8291
PC 02/11 - 8291
PC 02/11 - 8291

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12912

CERTIFICATE OF DEATH

12926

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN lb <u>6 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>25 E. Riverdale</u>		d. STREET ADDRESS <u>5423 55th Pl.,</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Valencia Stewart</u>		First	Middle	Last	4. DATE OF DEATH <u>Nov 3 1959</u>	Month	Day	Year	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-21-33</u>		9. AGE (In years last birthday) yrs. <u>27</u>	IF UNDER 1 YEAR Months <u>0</u>	IF UNDER 24 HRS Hours <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Arthur C Krites</u>		14. MOTHER'S MAIDEN NAME <u>Zora V Swisher</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>577 42 6474</u>		INFORMANT <u>Robert C Stewart</u>		Address <u>E Riverdale, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>660.5</u> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <u>Acute pulmonary edema</u> DUE TO <u>Term pregnancy & Cesarean section</u> . (c)									
INTERVAL BETWEEN ONSET AND DEATH									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>5102 Annapolis Rd. Bladensburg</u>		(County) <u>Md.</u>	(State) <u>Md.</u>
21. I certify that I attended the deceased from <u>4/7</u> , 19 <u>59</u> , to <u>11/3</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11/3</u> , 19 <u>59</u> , and that death occurred at <u>11:00A.M.</u> from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) <u>5102 Annapolis Rd. Bladensburg, Md.</u>									DATE SIGNED <u>11/4/59</u>
ACTUAL SIGNATURE <u>Julius Kauffman</u>		M.D.							
PHYSICIAN'S NAME (Type) <u>Dr Julius Kauffman, M.D.</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/7/59</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>Ft Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) <u>Colmar Manor, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 10 '59</u>			24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		

1. *Leucosia* *leucostoma* (Fabricius) *leucostoma* (Fabricius)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12913

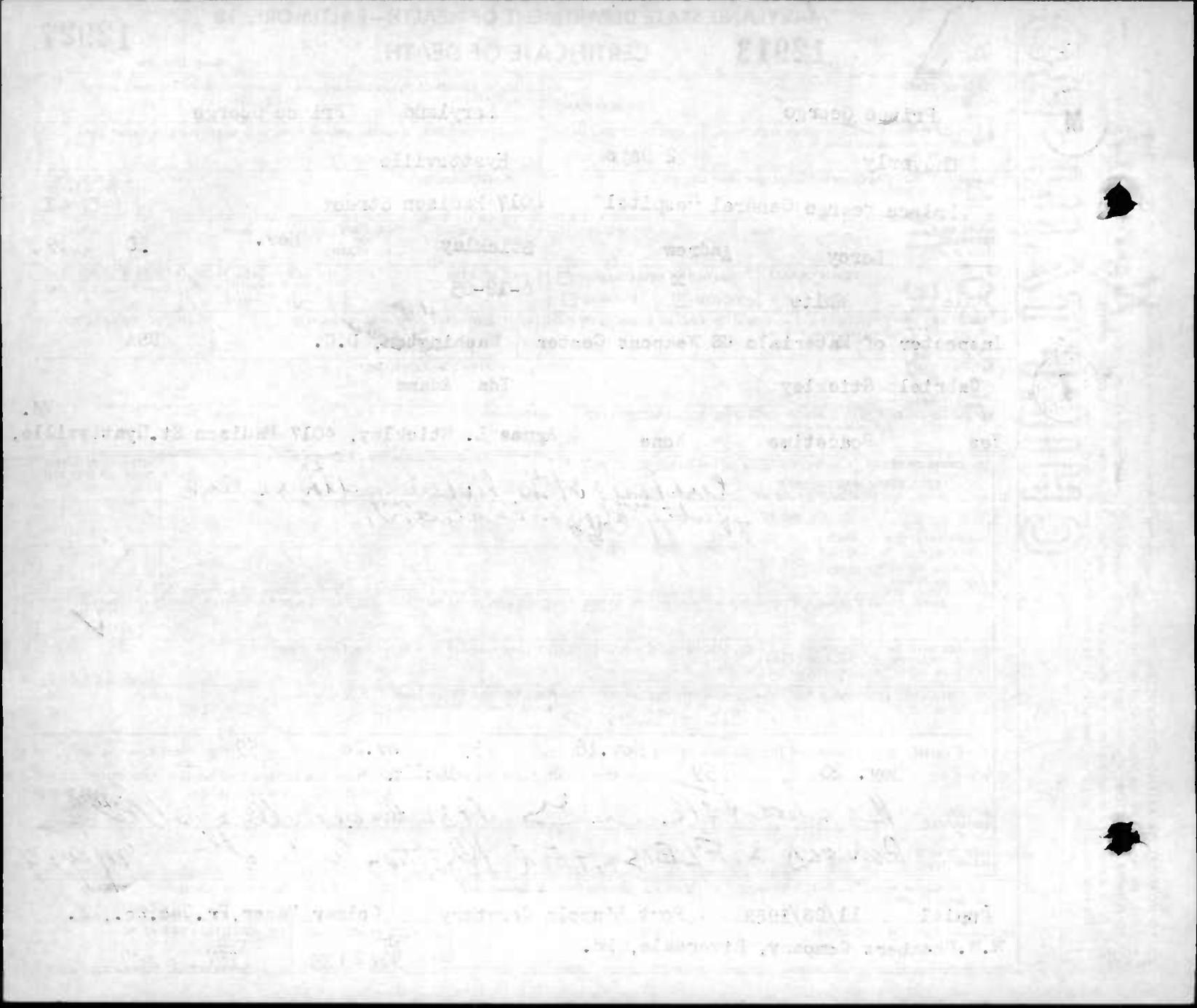
CERTIFICATE OF DEATH

Reg. Dist. No.

12927

1 *X*
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Prince George		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 2 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Leroy	First Andrew	Middle Stickley	4. DATE OF DEATH Nov. Month 20 Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-12-05
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector of Materials		10b. KIND OF BUSINESS OR INDUSTRY US Weapons Center	11. BIRTHPLACE (State or foreign country) Washington, D.C.
13. FATHER'S NAME Gabriel Stickley		14. MOTHER'S MAIDEN NAME Ida Adams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. Peacetime	INFORMANT Agnes L. Stickley, 4017 Madison St. Hyattsville,	Address Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) Syphosis of the liver, with severe fatty degeneration. INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov. 18 , 1959, to Nov. 20 , 1959, that I last saw the deceased alive on Nov. 20 , 1959, and that death occurred at 10:10 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Ronald S. Fleischer</i>	ADDRESS (Street, city or town, state) <i>1532 Queens Anne Rd. M.D.</i>		DATE SIGNED <i>11/29/59</i>
PHYSICIAN'S NAME (Type) Ronald S. Fleischer			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/23/1959	22c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Colmar Manor, Prince George Co., Md.
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.		ADDRESS	24a. REC'D BY REGISTRAR DATE NOV 24 '59
			24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12928

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar, and 3 to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		c. LENGTH OF STAY IN 1b 2 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 352 Main Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Wilhelmine		First Reinhilde	Middle Stumpf
4. DATE OF DEATH November 11 1959	Last	Month	Day
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 5-14-12	9. AGE (In years last birthday) 47 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY Germany	
13. FATHER'S NAME Ferdinand Hammer		14. MOTHER'S MAIDEN NAME Marie Kempf	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Karl Stumpf; same address	
17. INFORMANT Karl Stumpf; same address		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Spontaneous intracerebral Hemorrhage DUE TO 331X			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral hypertension			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Cardiovascular renal disease			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>John T. Maloney</i>		DATE SIGNED M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		November 11, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/14/59	22c. NAME OF CEMETERY OR CREMATORIAL Cerner Mem Park	22d. LOCATION (City, town, or county) Maryland (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>De Witt Danaldson Laurel, Md</i>		ADDRESS	24a. REC'D BY REGISTRAR DATE NOV 18 '59
			24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

STATE OF CALIFORNIA
DEPARTMENT OF MOTOR VEHICLES
EXAMINER'S CERTIFICATE

REG. NO.

REG'D.

REG'D.

REG'D.

EXPIRATION DATE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

14087

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your [redacted] or removed.

1. PLACE OF DEATH a. COUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Alexander	Middle Francis	Last Sutherland
4. DATE OF DEATH Month November	Day 23	Year 1959	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-26-13
9. AGE (in years last birthday) 46 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Book binder	10b. KIND OF BUSINESS OR INDUSTRY G.P.O.	11. BIRTHPLACE (State or foreign country) Massachusetts	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Walter Sutherland	14. MOTHER'S MAIDEN NAME Margaret Fey		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no) Yes	16. SOCIAL SECURITY NO. 803-91-61	17. INFORMANT Ruth E. Sutherland; same address as # 2.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Cerebral compression INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Intracerebral hemorrhage			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>John T. Maloney</i>	DATE SIGNED M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) John T. Maloney, M.D.	November 23, 1959		
22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation	22b. DATE THEREOF 11/24/59	22c. NAME OF CEMETERY OR CREMATORIAL Conway Funeral Home	22d. LOCATION (City, town, or county) Peabody (State) Massachusetts
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons	ADDRESS Hyattsville, Md.	24a. REC'D BY REGISTRAR DATE NOV 25 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

WEDDING EXCHANGE CERTIFICATE OF GIFT

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12929

Reg. Dist. No.

12916

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar, or to burial, cremation, or removal.

1. PLACE OF DEATH o. COUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First John	Middle Arthur	Last Taylor
4. DATE OF DEATH	Month November	Day 9,	Year 19 59
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-19-13
9. AGE (In years last birthday) 46 yr.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor	10b. KIND OF BUSINESS OR INDUSTRY G.P.O. Field Serv.	11. BIRTHPLACE (State or foreign country) Washington, D.C.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Robert Taylor	14. MOTHER'S MAIDEN NAME Nellie Padgett		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. W.E. 2	17. INFORMANT Cicelia Taylor; same address as # 2.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary and cerebral edema			
434.1 DUE TO Conditions, if any, which goe rise to immediate cause (a), stating the underlying cause last.			
(b) Acute congestive heart failure			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>John T. Maloney</i>	DATE SIGNED		
EXAMINER'S NAME (Type) John T. Maloney, M.D.	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov 13, 1959	22c. NAME OF CEMETERY OR CREMATORIUM Arlington National	22d. LOCATION (City, town, or county) Arlington Va
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.	ADDRESS	24a. REC'D BY REGISTRAR NOV 16 1959	24b. REGISTRAR'S SIGNATURE Arthur & Francis

STATE OF TEXAS
DEPARTMENT OF HUMAN SERVICES
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Date of Birth:		Place of Birth:	Date of Death:	Place of Death:
Name of Deceased:		Cause of Death:		
Relationship to Deceased:		Signature of Physician:		
Address:		Signature of Hospital or Institution:		
Phone Number:		Signature of Coroner:		
Social Security Number:		Signature of Medical Examiner:		
Date:		Date:		

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12917

CERTIFICATE OF DEATH

Reg. Dist. No.

12930

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY <i>Prince George</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Riverdale</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Riverdale</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Liland Memorial Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Geotrade</i>		First <i>Elizabeth</i>	Middle <i>Troy</i>
4. DATE OF DEATH <i>Nov. 6 1959</i>		Month <i>Nov.</i>	Day <i>6</i>
5. SEX <i>Fem</i>	6. COLOR OR RACE <i>Wh</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>Nov 15, 1877</i>
9. AGE (In years last birthday) <i>82 yrs.</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Wash., D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Augustus Berkley</i>		14. MOTHER'S MAIDEN NAME <i>Mary E Horstamps</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Unknown</i>		16. SOCIAL SECURITY NO. <i>123-45-6789</i>	
17. INFORMANT <i>Son, John W Troy</i>		Address <i>854 N. Lebanon Arlington, VA</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Intestinal Obstruction</i>			
INTERVAL BETWEEN ONSET AND DEATH			
570.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) mesenteric Thrombosis			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Oct 29, 1959</i> , to <i>Nov. 1, 1959</i> , that I last saw the deceased alive on <i>Nov 1, 1959</i> , and that death occurred at <i>5 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Theodore Zegarra, M.D.</i>		ADDRESS (Street, city or town, state) <i>4408 Queenbury Rd., Stowoke, Ma.</i>	
PHYSICIAN'S NAME (Type) <i>Theodore Zegarra, M.D.</i>		DATE SIGNED <i>11-1-59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Nov. 4, 1959</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>FT. LINCOLN</i>		22d. LOCATION (City, town, or county) <i>Pr. Geo Co., Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W.W. Chambers Co.</i>		24a. REC'D BY REGISTRAR DATE <i>NOV 3 '59</i>	
ADDRESS <i>5801 Cleveland Ave., Riverdale, Md.</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Ward</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G255 12/4/59 iwk

12918

12931

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince George</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>Prince George</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Riverdale</i>		c. LENGTH OF STAY IN lb <i>5 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Riverdale</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Belmont Memorial Hospital</i>		d. STREET ADDRESS <i>1620 2 Carrollton Terrace</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Anne</i>	Middle <i>Elizabeth</i>	Last <i>Turner</i>	4. DATE OF DEATH <i>11</i>	Month <i>- 11</i>	Day <i>26</i>	Year <i>1959</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-6-90 1880</i>	9. AGE (In years lost birthday) <i>79 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Run Home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Horace A. Harrison</i>				14. MOTHER'S MAIDEN NAME <i>Julia Athey</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>✓</i>		17. INFORMANT <i>Hospital Record/Miss Eunice Turner Daughter</i>		Address <i>As above</i> <i>Rhode Villa 77246</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Edema of brain</i>		DUE TO <i>151X</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2-3 days</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. <i>Cancerous (adeno) of Stomach</i>		DUE TO <i>(b)</i>		DUE TO <i>(c)</i>		<i>1 year</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>11-20</i> , 19 <i>59</i> , to <i>11-26</i> , 19 <i>59</i> that I last saw the deceased alive on <i>11-25</i> , 19 <i>59</i> , and that death occurred at <i>4:30 A.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Riverdale Md.</i>		DATE SIGNED <i>Nov 26, 1959</i>			
ACTUAL SIGNATURE <i>K. Wilkinson</i>		M.D.					
PHYSICIAN'S NAME (Type) <i>R. Wilkinson</i>		Riverdale Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Nov 28, 1959</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Union Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Burtonsville, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gasch's Sons</i>		ADDRESS <i>Hyattsville, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>NOV 30 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Charles S. Krause</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After his certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 or 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

87. BROMITIAR—MENTAL DEPARTMENT OF THE UNIVERSITY OF CALIFORNIA

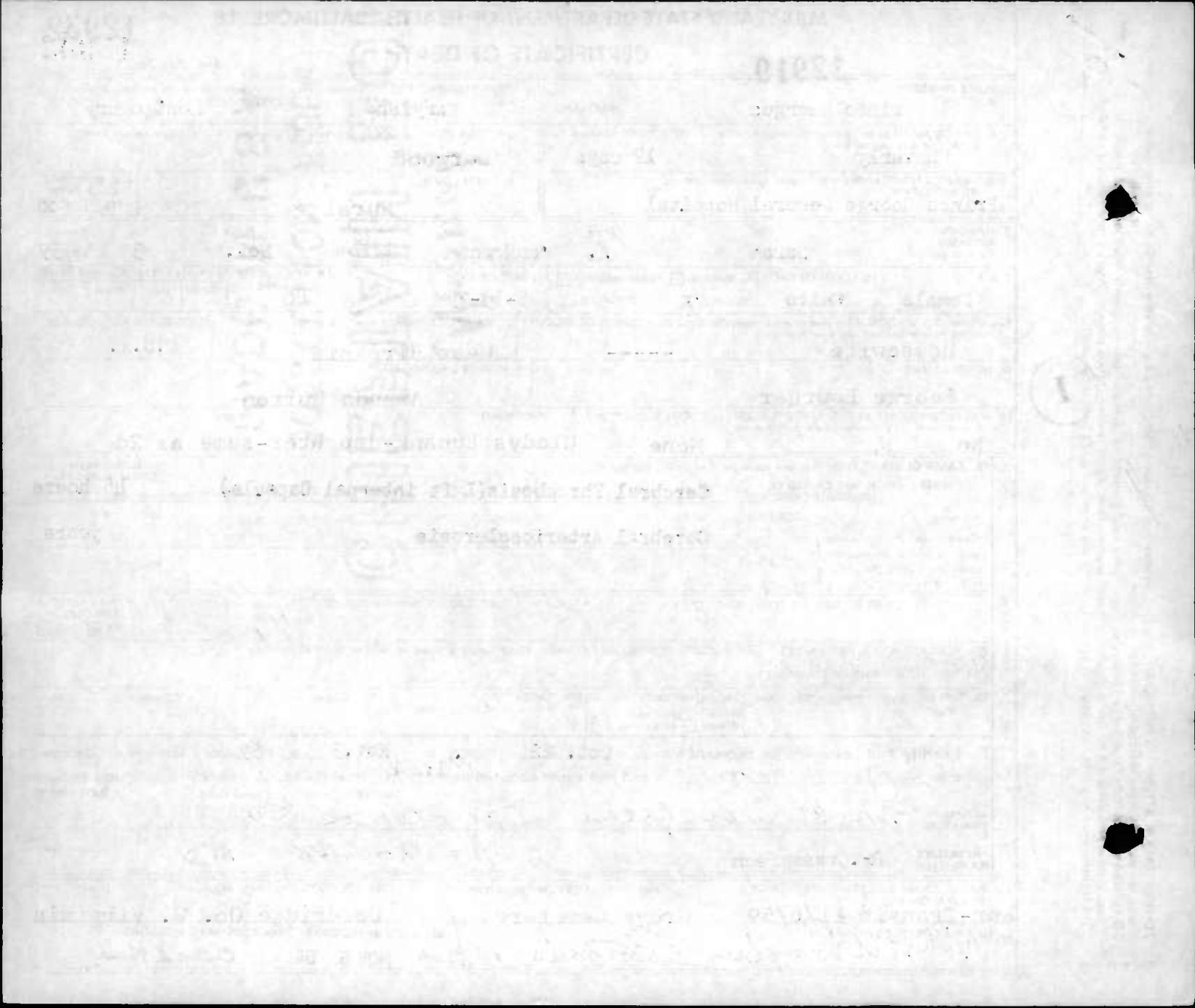
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12932

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly	c. LENGTH OF STAY IN 1b 12 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Derwood 15X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		d. STREET ADDRESS Rural	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Sarah	First Sarah	Middle A.	Last VanHorn
4. DATE OF DEATH Nov. 3 1959	Month Nov.	Day 3	Year 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-13-79
9. AGE (In years last birthday) 80 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. KIND OF BUSINESS OR INDUSTRY -----	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME George Lowther	14. MOTHER'S MAIDEN NAME Amanda Burton		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	INFORMANT Gladys Eubank-daughter-same as 2d	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X DUE TO Cerebral Thrombosis (Left internal Capsule) INTERVAL BETWEEN ONSET AND DEATH 48 hours Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO Cerebral Arteriosclerosis years (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct. 22, 1959, to Nov. 3, 1959, that I last saw the deceased alive on 19, and that death occurred at 1:25 P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John W. Grassgreen</i>	ADDRESS (Street, city or town, state) M.D. 301 ARUNDEL RD. Mt. RAINIER, MD.		
PHYSICIAN'S NAME (Type) Dr. Grassgreen	DATE SIGNED		
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit 11/6/59	22b. DATE THEREOF 11/6/59	22c. NAME OF CEMETERY OR CREMATORIUM Grove Cemetery	22d. LOCATION (City, town, or county) (State) Doddridge Co. W. Virginia
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Humphrey</i>	ADDRESS <i>Bethesda, Md.</i>	24a. REC'D BY REGISTRAR DATE NOV 5 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Tracy</i>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12920

CERTIFICATE OF DEATH

12934

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryalnd		b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Brentwood		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 34 North Brentwood					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4506 41st Avenue		d. STREET ADDRESS 1 4506 41st Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Martha		First	Middle J. Wallace	Last	4. DATE OF DEATH 11/9/59	Month	Day 19	Year	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 5/28/1874		9. AGE (in years lost, birthday) 85 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Otha Johnson		14. MOTHER'S MAIDEN NAME Elizabeth --							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Otelia Muggs		Address 1207 48th St., N. E., D. C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis 422.2		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) 		INTERVAL BETWEEN ONSET AND DEATH 2 yrs			
DUE TO 		(c) 							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day 	Year 	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 5201 Balto. Ave.	20f. (City or town) Hyattsville	(County) 	(State) 	
21. I certify that I attended the deceased from Nov. 9 , 19 59 , to Nov. 9 , 19 59 , that I last saw the deceased alive on Nov. 9 , 19 59 , and that death occurred at Hyattsville, Md. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Hyattsville, Md. DATE SIGNED Leonard Hays 11-11-59									
ACTUAL SIGNATURE Leonard Hays	PHYSICIAN'S NAME (Type) Leonard Hays	M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/11/59	22c. NAME OF CEMETERY OR CREMATORIAL Carver Memo Cemetery		22d. LOCATION (City, town, or county) Prince Georges Co., MD.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Norman J. Hays		ADDRESS 1820 1/2 St. NW		24a. REC'D BY REGISTRAR DATE NOV 12 '59	24b. REGISTRAR'S SIGNATURE Carmer S. Hayes				

MASSACHUSETTS STATE DEPARTMENT OF PUBLIC WELFARE

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12935

Reg. Dist. No.

12921

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chesapeake</i>		c. LENGTH OF STAY IN lb <i>200</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Prince George San Hosp</i>		e. STREET ADDRESS <i>6107 - K. Street</i>	
3. NAME OF DECEASED (Type or print) <i>Eula Mae</i>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
g. SEX <i>Female</i>		h. COLOR OR RACE <i>Colored</i>	
i. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		j. DATE OF BIRTH <i>0-16-1918</i>	
k. AGE (In years from birthday) <i>41 yrs.</i>		l. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>	
m. IF UNDER 24 HRS.		n. IF UNDER 24 HRS.	
o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Tobacco farmer</i>		p. KIND OF BUSINESS OR INDUSTRY <i>Zohreco</i>	
q. BIRTHPLACE (State or foreign country) <i>S. Carolina</i>		r. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
s. FATHER'S NAME <i>Bud Walters</i>		t. MOTHER'S MAIDEN NAME <i>Cinnabelle Watson</i>	
u. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) <i>No</i>		v. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
w. INFORMANT <i>Clarence Young</i>		x. Address <i>6107 J. St., Wto.</i>	
y. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>581.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <i>Acute congestive heart failure</i> <i>Hepatic failure</i> <i>Cirrhosis of the liver</i>			
z. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John T. Maloney</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <i>John T. Maloney MD</i>		DATE SIGNED <i>Nov. 7-1959</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>11-10-59</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Woodlawn</i>		22d. LOCATION (City, town, or county) (State) <i>WASHINGTON, D.C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John T. Rhinehart Co. 3015-128474</i>		ADDRESS <i>Washington D.C.</i>	
24a. REC'D BY REGISTRAR DATE <i>NOV 12 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Julian S. Evans</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

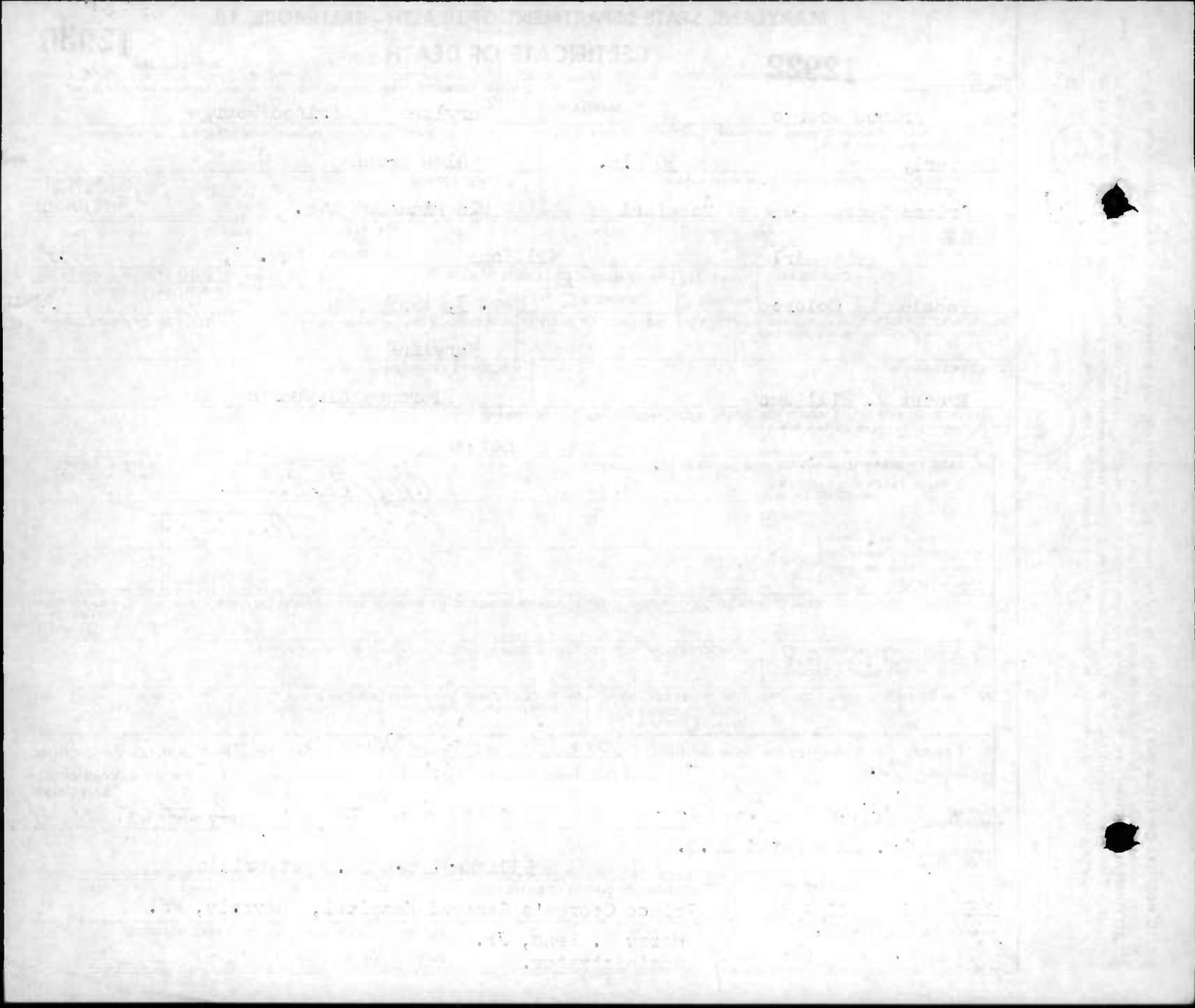
Reg. Dist. No.

12936

1. PLACE OF DEATH o. COUNTY Prince George		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY Maryland Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 30 Min.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby Girl	First Baby Girl	Middle Williams	Last Nov. 3, Month 1959 Day Year 30Min
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 3, 1959
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Ernest J. Williams		14. MOTHER'S MAIDEN NAME Florence Clayborne	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. INFORMANT Mother	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
INTERVAL BETWEEN ONSET AND DEATH Prematurity			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 3, 1959 , to Nov. 3, 1959 , that I last saw the deceased alive on Nov. 3, 1959 , and that death occurred at 6:45 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John W. Perkins</i>		ADDRESS (Street, city or town, state) 5301 Hamilton St., Hyattsville	
PHYSICIAN'S NAME (Type) Dr. John Perkins M.D.		DATE SIGNED 11/4/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 11/9/59	
22c. NAME OF CEMETERY OR CREMATORIAL Prince George's General Hospital		22d. LOCATION (City, town, or county) (State) Cheverly, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Harry W. Penn</i>		24a. REC'D BY REGISTRAR ADDRESS Harry W. Penn, Jr. Administrator	
		24b. REGISTRAR'S SIGNATURE NOV 13 '59	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12937

CERTIFICATE OF DEATH

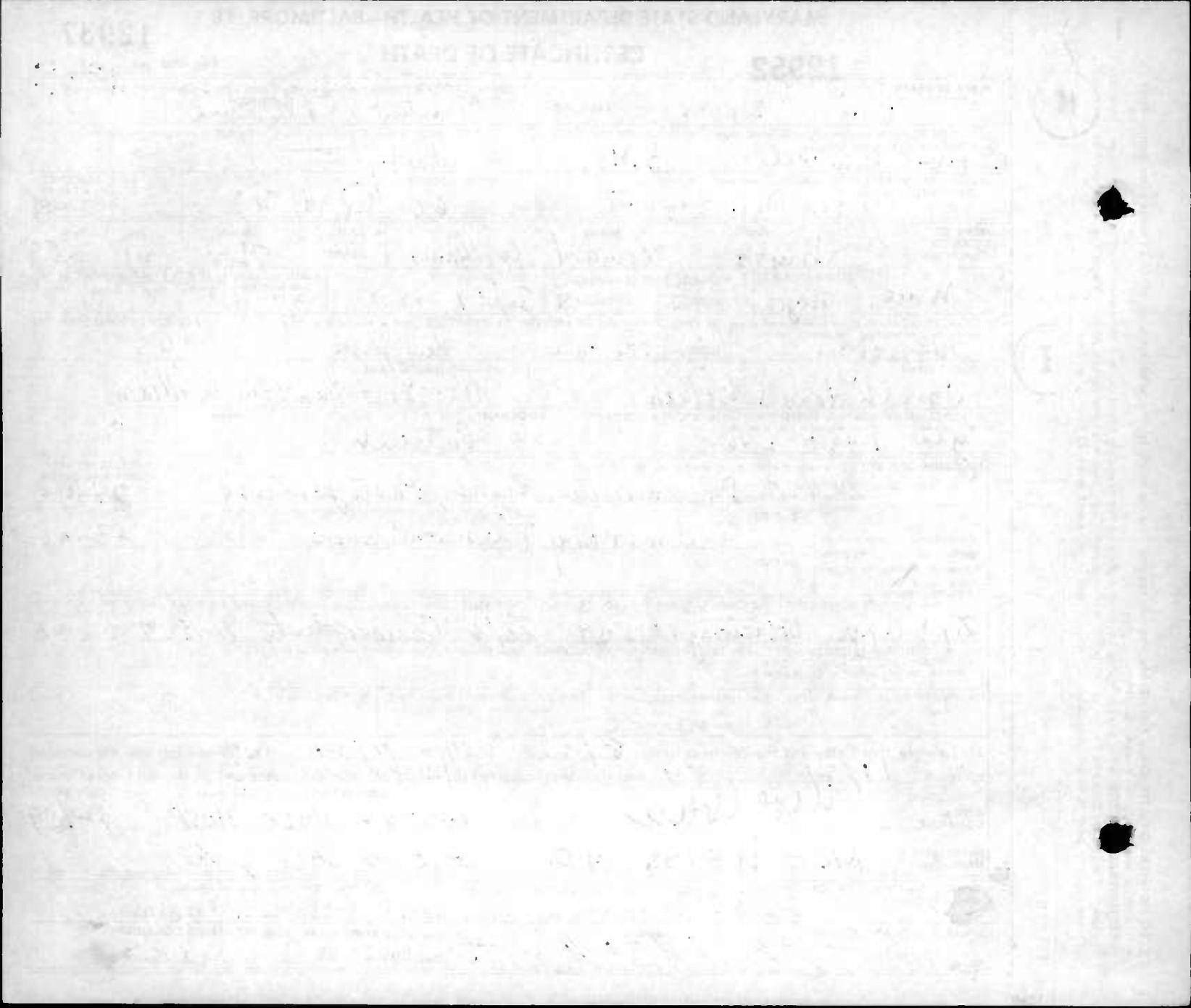
Reg. Dist. No.

12952

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE	
Prince George's Maryland		District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb 3 Mo	
Luray-Glen Dale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wardsburg 47x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glen Dale Hospital		d. STREET ADDRESS 60 Q st N.E.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) James Howard Williams		4. DATE OF DEATH Month Nov Day 21 Year 1959	
S. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Sept 1 1922
9. AGE (In years lost birthday) 37 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Messenger	10b. KIND OF BUSINESS OR INDUSTRY Internal Revenue	11. BIRTHPLACE (State or foreign country) New Jersey
12. CITIZEN OF WHAT COUNTRY? U.S.	13. FATHER'S NAME Joseph Howard Williams		
14. MOTHER'S MAIDEN NAME Margaret Hampton Williams	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes 1943 to 2-46		
16. SOCIAL SECURITY NO. 11-43-246		INFORMANT Patient	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonitis, Right, Post-operative 002X DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary Tuberculosis DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Left upper lobectomy 10-5-59; Left Thoracoplasty 11-18-59			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8/21, 1959, to 11/21, 1959, that I last saw the deceased alive on 11/7, 1959, and that death occurred at 12:10 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) MOE WEISS, M.D.		ADDRESS (Street, city or town, state) M.D. GLENN DALE HOSP. DATE SIGNED 11/21/59	
22a. BURIAL CREMATION, REMOVAL (Specify) 11/22/59	22b. DATE THEREOF 11/22/59	22c. NAME OF CEMETERY OR CREMATORIAL Arlington National Cem.	22d. LOCATION (City, town, or county) Arlington, Virginia (State)
23. FUNERAL DIRECTOR'S SIGNATURE John T. Stewart 3148078		ADDRESS	24a. REC'D BY REGISTRAR DATE NOV 27 '59
			24b. REGISTRAR'S SIGNATURE Celia S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12859 CERTIFICATE OF DEATH 12938 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Prince Georges</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Mt. Rainier</i>		c. LENGTH OF STAY IN lb RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Mt. Rainier</i>		d. STREET ADDRESS <i>14218-34th Street</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>4218-34th Street</i>				d. STREET ADDRESS <i>14218-34th Street</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>John H. Wolfe</i>		First	Middle	Last	4. DATE OF DEATH <i>Nov. 9th 1959</i>	Month	Day	Year
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 20, 1881</i>		9. AGE (In years last birthday) yrs. <i>77</i>	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Tool maker, Ret. Navy Yard, D.C.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Baltimore, Md</i>		11. BIRTHPLACE (State or foreign country) <i>U.S.</i>		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <i>Louis Wolfe</i>		14. MOTHER'S MAIDEN NAME <i>Mary Catherine Gaffey</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>577-40-5925</i>		INFORMANT <i>Pansy Irene Wolfe - wife</i>		Address <i>above</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0</i> DUE TO <i>Anemone-sclerotic Heart Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <i>with coronary occlusion (syn. S.C.)</i> (c) <i>and peripheral congestive heart failure.</i> INTERVAL BETWEEN ONSET AND DEATH <i>3 years.</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>M.D. 1746-B Shady St. Wards, D.C.</i>		20f. (City or town) (County) (State) <i>Colmar Manor, Md.</i>		
21. I certify that I attended the deceased from <i>Sept. 4, 1956</i> , to <i>Nov. 9, 1959</i> , that I lost sow the deceased olive on <i>Nov. 9, 1959</i> , and that death occurred at <i>1 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>John J. Feuerstein</i> DATE SIGNED <i>4/19/59</i>								
ACTUAL SIGNATURE <i>John J. Feuerstein</i>								
PHYSICIAN'S NAME (Type)		22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> 22b. DATE THEREOF <i>11/12/59</i> 22c. NAME OF CEMETERY OR CREMATORIAL <i>Fort Lincoln</i> 22d. LOCATION (City, town, or county) (State) <i>Colmar Manor, Md.</i>						
23. FUNERAL DIRECTOR'S SIGNATURE <i>Nalley's Funeral Home, Mt. Rainier, Prince, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>NOV 12 '59</i> 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frame</i>						

